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THE JOURNAL OF THE
# IOWA MEDICAL SOCIETY

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• ICF and Iowa Physicians—Page 7
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JANUARY 1975

# Both often

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**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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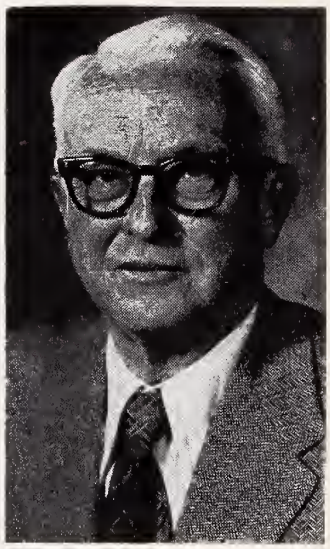
# President's Page



The "sounds and fury" at the December session of the AMA House of Delegates were impressive. The day-to-day business of the AMA is guided by the Board of Trustees based on policy set by the House. In the past five years deficit spending has depleted reserves to a critical level. Inflation is partly responsible but many delegates feel there are other reasons for the deficit.

Opinions and criticisms were presented openly at the reference committee hearings and on the floor of the House. Board members defended their actions vigorously. Previous House actions, e.g., not granting a full dues increase several years ago, were noted as being part of the problem.

It was conceded the trustees need more funds to operate Association programs and activities. To this end, the delegates voted an "assessment" ($60) for 1975. In addition, it was decided a thorough study of the dues structure should be made with a report at the June 1975 meeting. Further discussion will occur then. Meantime, there will be opportunity to study the Board's actions in terminating various councils, committees and programs. A more detailed analysis of AMA real estate acquisition may be part of the June report.

Other issues under discussion were related to national health insurance, medical liability and continuing medical education. PSRO, which has been a key topic, occupied a minor position.

I came away feeling our Iowa Medical Society performs well in representing and supporting its members in their task of delivering quality medical care.

Sincerely,

Ralph L. Wicks

*Ralph L. Wicks, President*

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# IOWA Medical Miscellany

**GENERAL ASSEMBLY . . .** The Iowa Legislature will convene January 13 with the following line-up: House—61 Democrats and 39 Republicans; Senate—25 Democrats and 24 Republicans (one seat is still to be filled).

**IMS STRATEGY . . .** IMS Legislative Committee is recommending 1975 Society emphasis on these measures: (1) adequate funding for the family practice residency programs, (2) granting of continuing medical education authority to the Board of Medical Examiners, and (3) legal immunity for physicians doing peer review work. Any pharmaceutical and chiropractic proposals will receive attention. A Committee report will be made to the IMS Executive Council this month. The Council has previously supported (a) the Board of Medical Examiners as the agency to implement CME through regulatory provision, and (b) a move from annual medical licensure to a three-year renewal approach.

**AMA ACTIONS . . .** IMS News Bulletin (12/10/74) highlighted actions taken by the AMA House of Delegates at its interim session. Lead story was approval of a special mandatory 1975 assessment ($60) of all AMA members, excluding interns, residents and medical students. Related action called for continued acceptance of advertising in medical journals; further study of need for dues increase with a report in June, 1975; and a moratorium on the termination of various AMA councils, committees, projects, etc. The fiscal status of AMA is to be evaluated by a special House committee and considered again in June.

**PHYSICAL THERAPY . . .** Discussion as to relationships between medicine, physical therapy and hospital administration occurred December 18 among representatives of the three groups. IMS representatives were M. W. Van Allen, M.D., Iowa City, D. C. Young, M.D., Des Moines, J. R. Anderson, M.D., Boone, and C. O. Lester, M.D., Marshalltown.

**'75 SCIENTIFIC SESSIONS . . .** Mailings advising of the 1975 IMS Scientific Session to be held April 3 to 8 in Freeport, Grand Bahama, have been sent to all Society members. Scientific presentations and roundtable discussions will be offered on three days. Reservations were invited and encouraged in the December mailings. Further inquiries may be directed to IMS Headquarters.

**SURGICAL CODING . . .** In line with efforts to promote physician acceptance and use of AMA/CPT, Blue Shield will adopt and follow the surgical modifiers contained in the AMA/CPT when full adoption of the system is undertaken in 1975.

**ON FAMILY PRACTICE . . .** IMS President R. L. Wicks, M.D., P. M. Seebohm, M.D., University of Iowa, and Society staff met in December with representatives of Governor Ray to discuss status of the family practice residency programs and to consider funding needs.

**OBESITY SURGERY . . .** Revised IMS guidelines for surgical treatment of obesity by intestinal by-pass have been approved by the IMS Executive Council. The four guidelines are available on request from IMS Headquarters.

**EMERGENCY SERVICES . . .** A preliminary Iowa emergency medical services plan of the Governor's EMS Advisory Committee is reported to be near completion. The plan will be submitted to the U. S. Department of Transportation. EMS planning will be ongoing over next several years and will be merged ultimately in the broad State Comprehensive Health Plan being developed by OCHP. An IRMP grant has been authorized to allow a staff person to work exclusively on EMS blueprint.

**CME . . .** IMS Committee on Medical Education and Hospitals will meet January 9. Session will include briefing by AMA official on IMS as a CME accrediting unit for the AMA.

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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JANUARY, 1975

## TABLE OF CONTENTS

ICF and Iowa Physicians . . . . . 7

Femoral Neck Fractures: Complications of Internal Fixation
Stuart L. Weinstein, M.D. . . . . 17

Carcinoma of the Rectum
W. H. DeKraay, M.D., G. C. Blome, M.D., K. E. Lister, M.D. and H. L. Wormhoudt, M.D. . . . . 22

An Unusual Cause of Carpal Tunnel Syndrome
O'Neil Engeron, M.D., and James O. Stallings, M.D. . . . . 25

### EDITORIALS

A New Year . . . . . 28

Weight-Reduction Weighed . . . . . 28

### SPECIAL DEPARTMENTS

President's Page . . . . . 4

Iowa Medical Miscellany . . . . . 5

The Question Box . . . . . 9

State Department of Health . . . . . 10

In the Public Interest . . . . . 16

Educationally Speaking . . . . . 30

About Iowa Physicians . . . . . 33

Deaths . . . . . 35

### MISCELLANEOUS

Nursing Home Actions . . . . . 8

Iowa Foundation for Medical Care . . . 21

Refresher Course for the Family Practitioner 29

Continuing Education Courses and Conferences . . . . . 30

Family Nurse Practitioners . . . . . 31

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*Postmaster, send form 3579 to the above address.*

# ICF and Iowa Physicians

*Understanding by Iowa physicians of the Intermediate Care Facilities program is important. Levels of care, certification and care review activities are discussed in this summary report.*

The number of patients in Iowa nursing homes receiving state or federal assistance is increasing annually. Because of this, Iowa physicians need to have a working knowledge of the Intermediate Care Facility (ICF) program. The mechanics of the ICF program are summarized here, particularly those pertaining to physicians.

The ICF program is one of 16 services available to eligible Iowans through the Title XIX Medical Assistance Program (Medicaid). The individual states administer the program under rules set forth by the Department of Health, Education and Welfare. Limited administrative flexibility is allowed to the states so long as compliance is maintained with federal law and regulation.

The ICF program is jointly funded by the state and federal governments with a 60% federal participation in Iowa.

## PHYSICIAN RESPONSIBILITIES

A major responsibility of physicians in the ICF program is that of certifying applicants. A medical assistance recipient may be placed in an ICF only upon certification of a licensed physician. The physician must certify that need for intermediate nursing care exists. This certification is completed on State Department of Social Services Form MA-2130-0. Nursing homes are responsible for initiating the form in four copies and they must forward them to the physician.

The physician completes his portion of the form, files one copy in his records, and returns the remaining copies to the facility for further disposition. Proper placement of applicants in nursing homes requires a knowledge of accepted standards for levels of care. Most applicants for medical assistance will require one of the following three levels of care:

**Skilled (Extended) Care:** In determining whether a patient requires the level of care covered under the skilled care benefit, three factors must be considered: (1) Whether skilled nursing or other skilled rehabilitation services are required; (2) Whether such services are required on a daily basis; and (3) Whether, as a practical matter, the care can *only* be provided in a skilled nursing home on an inpatient basis.

**Intermediate Care Facility (Basic or Intermediate Nursing Home):** The distinguishing factor for admission to an intermediate care facility must be the need for professional nursing services on a regular and frequent basis. In the evaluation of an individual's needs, these criteria are represented as guides to aid physicians, nurses and other health professionals in exercising judgment. They are not rigid standards.

**Custodial Care:** Placement in a custodial home is accomplished by the written order of an individual's personal physician. The physician certifies the individual being admitted requires only personal assistance in daily living and does not require nursing care.

## RECERTIFICATION

Recent federal legislation calls for recertification of the need for care and services provided to Title XIX ICF residents every 60 days. To facilitate the recertification process, the Department of Social Services has determined that progress notes and a physician's signature on an ICF resident's chart constitutes compliance. Physicians may make these notes during their regular visits to residents in nursing homes. At the same time, Iowa physicians should review the treatment and medication provided to residents under their care and make an ongoing assessment as to the appropriateness of the level of care.

If, for any reason, the physician is unable to see the resident in the 60-day certification period,

This discussion of the Intermediate Care Facilities Program has been provided by the State Department of Social Services and has been prepared by E. M. Smith, M.D., Acting Director, Bureau of Medical Services, and Linda Cooper, Director, Long Term Care Section.

Form MA-2130-0 will be used for recertification. The form will be initiated by the ICF and forwarded to the physician. The physician will be asked to complete his portion of the form and indicate a reason for not seeing resident during the 60-day period. He will be asked to note the date on which he will next see the resident. The completed form is to be returned to the ICF to be filed with the resident's chart.

The Department of Social Services pays physicians a $3 fee for each recertification whether it is accomplished on the resident's chart or on Form MA-2130-0.

### CARE REVIEWS

HEW requires the DSS to conduct resident care reviews and evaluations of all Title XIX residents who receive care in intermediate care facilities. These teams, consisting of a registered nurse and a social worker, will visit each nursing home certified as an ICF at least annually. The goals of resident care review teams are threefold: (a) To identify services that could be better utilized to the advantage of residents; (b) To provide consultation and inservice training to ICF personnel, and (c) To affect a uniformly high level of nursing care throughout Iowa.

As both physicians and review teams desire a high level of nursing care, a major effort is being made to achieve cooperation and understanding. Physician consultants assigned to the review teams are providing a communications link between the profession and the DSS. A physician consultant is available to each team, and he is to be consulted by team members whenever circumstances require medical expertise. The consultants are also available to answer questions from practicing physicians.

At present, review teams are located in the western half of Iowa. The physician consultants now serving are:

Robert Q. Christensen, M.D., Carroll; Otto N. Glesne, M.D., Ft. Dodge; Rosalie Neligh, M.D., Council Bluffs; J. C. Nolan, M.D., Corning; J. E. Reeder, Jr., M.D., Sioux City; Donald F. Rodawig, Jr., M.D., Spirit Lake; Herman J. Smith, M.D., Des Moines, and L. W. Swanson, M.D., Mason City.

Any Iowa physician or county medical society that would like more information on care review or other aspects of ICF program is invited to contact Elmer M. Smith, M.D. (515/281-3359) or Linda Cooper (515/281-5586) at the SDSS Bureau of Medical Services, Des Moines.

## Nursing Home Actions

The Iowa Medical Society Executive Council approved the following six recommendations submitted by the Subcommittee on Medical Practice in Health Facilities and Homes on October 30.

1. That the IMS support and urge the construction of more nursing and custodial homes, particularly in shortage areas, so as to accommodate those persons who will have to be relocated with the closing of older facilities and to serve the increasing number of older Iowans who may require this type of housing.

2. That the IMS support realistic reimbursement schedules for the nursing and custodial homes so that satisfactory living conditions can be provided.

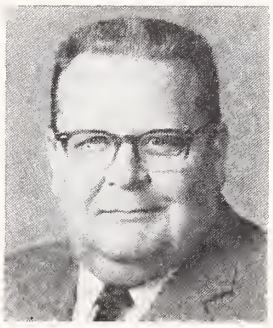
3. That the IMS support the prudent use of health care personnel, balancing the availability of funds with the need for adequate services. That in this regard, staffing of a facility be determined in line with its size and bed capacity following guidelines which permit some flexibility. For example, local facility sharing of dietitians, recreation directors, etc., appears prudent with time allocated on the basis of the number of patients.

4. That the IMS support efforts to combine the inspections which are required of the various facilities, this in an attempt to foster governmental economy and reduce the time needed to accomplish this activity.

5. That the IMS support and work with appropriate state agencies to obtain greater physician understanding of the nursing and custodial home program in Iowa, this to be achieved through informational presentations at county medical society or district medical meetings and through use of the IMS JOURNAL and other publications. And as a logical extension of this, record IMS support for increased local dialogue between physicians and nursing home administrators.

6. That the IMS stress the importance of physicians following up on their nursing home orders to see they have been implemented, and also advocate a yearly maintenance physical examination with appropriate laboratory tests for each nursing home patient, with a further strong recommendation that government pay adequately for this service when it is responsible.

# The Question Box



by R. C. HARDIN, M.D.

*Dr. Hardin has been in administrative endeavor for 12 years. He has chosen to leave his University of Iowa post as Vice-President and Dean for Health Affairs January 1. He will return to teaching and patient care as a professor of internal medicine.*

**How would you characterize your 12 years on the administrative side of health education?**

Busy. No segment of higher education has changed as much in the past decade as the health sciences. Graduates from these programs across the nation have doubled in number. Due largely to the availability of federal funds, biomedical research in universities has increased sixfold since 1960. Scientific knowledge has grown explosively. Medical schools have led all of higher education in self study and curriculum review and the other health disciplines have not been far behind. Postgraduate education (residency training) in medicine and dentistry has grown as new knowledge multiplied and has culminated in the development of programs in family medicine and community dentistry. To house this increased activity there has been a building boom on health campuses and the concept of the integrated academic health center has emerged. The University of Iowa has participated fully in all these developments, and this has required the concerted efforts of the faculty, staff and administration. The administrator's role in such endeavors is gathering information, long-range planning, finance, coordination of effort and protection of quality.

**What two or three accomplishments of the past decade give you the most satisfaction?**

First, it must be said that the accomplishments in the health sciences at Iowa are the result of the combined efforts of many persons and not of any individual. Many could be listed, but I find three the most satisfying personally. Of these, the most important is the expansion of the four programs for production of health professionals—dentists, nurses, pharmacists and physicians. The most visible is the constellation of new buildings necessary to house the augmented programs. Among these is one which, for me, has special attraction —the Health Sciences Library. However, bricks and concrete do not make an educational institution; the faculty and staff do. Therefore, the most satisfying accomplishment, in my estimation, is the enlargement of the faculties without loss of quality. In fact, recruitment of new members was done in a manner which enhanced excellence and broadened the range of skills available for patient care and teaching. This, in turn, insures that the increased number of graduates will be of high quality.

**How has the nature of the relationship between practicing Iowa physicians and academia changed, improved, or what in this period of time?**

The relationship between the College of Medicine and Iowa's practicing physicians has always been excellent, and the College enjoys their individual and collective support. In the past few years the two groups seem to have drawn more closely together so that there is little of the "we and they" syndrome and more of the "us." It appears to me that this has resulted in part from reciprocal needs, e.g., the need for more continuing education to which the College responded and the need for community-based educational programs to which the practicing profession responded. Then, too, there have been outside forces which have impinged equally on both groups such as the necessity to develop a professional services review mechanism. Most important, of course, is that there have been so many persons of good will who have worked actively to maintain and improve the relationship. This group includes but is not limited to the present and past officers of

*(Please turn to page 12)*

# State Department of Health

## MAN, HIS ANIMALS AND SALMONELLA TYPHIMURIUM

The investigation of salmonella infections represents a significant portion of the annual workload for the public health worker. In Iowa, this is particularly true of public health nurses and health departments, especially in the metropolitan areas. Salmonellosis is one of the infectious diseases directly transmissible between animals and man. From time to time human illness can be attributed to an animal source, with both household pets and agricultural animals capable of participating. The Center for Disease Control's *Morbidity & Mortality Weekly Report* for the week ending October 19, 1974, carried a report of *S. typhimurium* infection in a family, probably acquired from pets fed on contaminated chicken and meat scraps. Since this episode so neatly describes the occasional salmonella hazard encountered by man in his relationships with his animals, the Infectious Disease Control Section of the Iowa State Department of Health provides the report to help Iowa physicians who may encounter the organism.

### SALMONELLOSIS—British Columbia

On November 4, 1973, a 14-year-old boy was seen in the emergency department of a local hospital with a 2-week history of influenza-like illness; his symptoms included diarrhea, vomiting, stiff neck, and polymyalgia. His left hand was swollen and quite painful so as to make movement of his fingers difficult. There was no other joint involvement. The wrist was splinted, and he was sent home with a supply of aspirin tablets.

Subsequently, on November 6, he visited the office of his family physician complaining that both feet were tender and painful and that he had difficulty walking. He was admitted to the hospital the same day. There was nothing of significance in his previous medical or family history to suggest a specific illness. Physical examination revealed a toxic, thin boy with generalized lymphadenopathy and a pulse rate of 100 per minute.

Examination of his joints revealed marked swelling and tenderness of the left wrist with some tenderness in the metacarpophalangeal joints. There was some tenderness in the region of both ankle joints and marked tenderness over the tarsus of both feet.

During the following admission, he was observed to have spiking temperatures as high as 38.5°C. He was treated with ampicillin 250 mg 4 times a day and enteric-coated aspirin. Blood investigation revealed a hemoglobin of 11.5 gm and a sedimentation rate of 117 ml/hr. The white blood cell count was 10,800 (differential: polymorphonuclear leukocytes 66%, lymphocytes 17%, monocytes 6%, eosinophils 5%). Although a blood culture was negative, a stool culture revealed the presence of *Salmonella typhimurium*, phage type 3, resistant to ampicillin. Stool specimens were collected from all family household contacts. The family consisted of the patient, his parents, and 6 other children. Subsequent reports on specimens submitted showed that the mother and 2 children at home were also infected with *S. typhimurium*, phage type 3. The father and the other 4 children were culture negative.

Further inquiry revealed that the family had kennels used for breeding both dogs and cats. Six kittens born in August 1973 had developed diarrhea. No symptoms were observed in the canine population. The patient, the 2 children with positive stools, and the mother, also positive, were the only family members regularly handling the litter boxes of kittens. At the time of the investigation there were 9 dogs and 11 cats on the premises. Six dogs and 3 cats were infected with *S. typhimurium*, phage type 3. All but 1 of the specimens of food fed the animals were negative. Minced raw chicken and meat scraps were contaminated with *S. typhimurium*, phage type 3. Frozen samples of the raw meat and poultry obtained from a

*(Please turn to page 13)*

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In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**INDICATIONS:** *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.
*Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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# The Role of the Detail Man

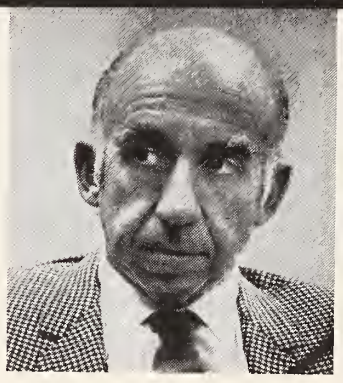
Opinion & Dialogue

**Dr. Willard Gobbell**
**Family Physician**
**Encino, California**

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

**Family Physician's Perception**

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



**Dr. Jeremiah Stamler**
**Chairman**
**Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology**
**Northwestern University Medical School**

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

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Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

**Is He a Source of Information?**

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

**Training of Sales Representatives**

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

**Value of Sampling**

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

---

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

**The Other Side of the Coin**

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

**The Industry Responsibility**

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

**Physician Responsibility**

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

*Pharmaceutical Manufacturers Association*
*1155 Fifteenth Street, N.W.*
*Washington, D.C. 20005*

P·M·A

## QUESTION BOX

*(Continued from page 9)*

the Iowa Medical Society and the present administration of the College of Medicine.

**What motivates your return to teaching and direct patient care?**

My return to the bedside and the classroom is dictated by two strongly held personal opinions. One is that administrators, at least in the field of health science education, have a definitely limited span of maximum effectiveness. The second is that periodic change in interests and goals is healthy and leads to enhanced productivity. My professional life has been divided into three roughly equal periods with three different interests—blood transfusion, diabetes and administration. This seems a good time to seek a fourth period and a fourth interest.

## Morbidity Report for November, 1974

| Disease | Nov. 1974 | 1974 to Date | 1973 to Date | From These Counties Most Cases Reported |
|---|---|---|---|---|
| Amebiasis | 1 | 31 | | Boone |
| Brucellosis | 1 | 17 | | Dubuque |
| Chickenpox | 923 | 7666 | 11694 | Audubon, Marshall, Story, Woodbury |
| Conjunctivitis | 198 | 935 | 958 | Carroll, Grundy, Johnson, Polk |
| Encephalitis assoc. w/ECHO 4 | 1 | 5 | 1 | Humboldt |
| assoc. w/Herpes simplex | 2 | 2 | | Johnson, Polk |
| Erythema infectiosum | 22 | 568 | 1343 | Clay, O'Brien, Wright |
| Gastrointestinal viral inf. | 5424 | 14686 | 6614 | Bremer, Dallas, Johnson, Marion |
| Hand, Foot & Mouth assoc. w/Coxsackie A16 | 1 | 7 | | Johnson |
| Hepatitis, A (Infectious) | 28 | 258 | 217 | Guthrie, Linn, Polk, Woodbury |
| Hepatitis, B (Serum) | 9 | 84 | 49 | Scattered |
| Hepatitis, type unspecified | 8 | 47 | 21 | Clinton, Washington |
| Histoplasmosis | 7 | 19 | 10 | Scattered |
| Impetigo | 137 | 600 | 426 | Harrison, Johnson, Linn, Winneshiek |
| Infectious Mononucleosis | 205 | 1048 | 669 | Black Hawk, Johnson, Lee, Linn |
| Influenza-like illness | 5289 | 100183 | 13502 | Bremer, Dallas, Linn, Madison, Polk |
| Meningitis Aseptic | 4 | 56 | 16 | Black Hawk, Dickinson, Linn, Polk |
| Meningococcal | 2 | 9 | 21 | Clinton, Page |
| *H. influenza* | 1 | 5 | | Iowa |
| Type unspecified | 5 | 42 | 32 | Buena Vista, Howard, Johnson, Wapello |
| Mumps | 98 | 1888 | 3613 | Black Hawk, Johnson, Union |
| Myocarditis, unknown etiology | 1 | 1 | | Hancock |
| Pediculosis | 253 | 677 | 187 | Benton, Linn, Marshall, Poweshiek |
| Pertussis | 1 | 15 | 20 | Polk |
| Pinworms | 5 | 62 | | Polk |
| Pneumonia | 140 | 923 | 1067 | Johnson, Marion, Scott |
| assoc. w/Adenovirus | 1 | 1 | | Johnson |
| Rabies in Animals | 6 | 118 | 208 | Scattered |
| Rheumatic fever | 2 | 54 | | Audubon, Bremer |
| Ringworm, body | 45 | 232 | 148 | Linn, Lyon, Poweshiek |
| Ringworm, scalp | 3 | 15 | | Black Hawk, Cerro Gordo, Polk |
| Salmonellosis | 11 | 191 | 207 | Scattered |
| Scabies | 46 | 150 | 229 | Scattered |
| Shigellosis | 17 | 292 | 270 | Delaware, Dubuque, Polk |
| Streptococcal inf. | 1027 | 9357 | 6522 | Dubuque, Johnson, Marshall, Polk |
| Toxoplasmosis | 4 | 10 | | Clinton, Delaware, Lee, Polk |
| Trichuriasis | 1 | 6 | | Johnson |
| Tuberculosis, active | 13 | 115 | 117 | Scattered |
| Tuberculosis, inactive | 3 | 15 | 18 | Black Hawk, Cedar, Linn |
| Venereal Diseases: Gonorrhea | 561 | 5758 | 5966 | Black Hawk, Linn, Polk, Scott |
| Syphilis | 27 | 348 | 392 | Scattered |
| Lymphogranuloma Venereum | 2 | 2 | | Polk |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | | | |
|---|---|---|---|---|---|
| Coxsackie B2 | 1 | Eaton's agent | 4 | Herpes simplex | 12 |
| Coxsackie B4 | 1 | ECHO 9 | 1 | Herpes zoster | 5 |
| Cytomegalovirus | 2 | | | | |

## STATE DEPARTMENT OF HEALTH

*(Continued from page 10)*

nearby supplier for consumption by the animals were also found to be contaminated with *S. typhimurium* phage type 3.

By the end of December all members of the family except the patient had negative stool cultures. On the advice of the Health Unit, none of the infected persons received specific treatment. Significantly, the patient who had received cephaloridine in addition to a course of ampicillin was the last of the family members to become culture negative.

*(Reported by P. J. Reynolds, M.D., Ch.B., D.P.H., F.R.C.P., Director of Medical Health Officer, Central Vancouver Health Unit, Nanaimo, British Columbia, in the* EPIDEMIOLOGICAL BULLETIN *18:35-37, 1974.)*

### EDITORIAL NOTE

This incident illustrates a common pathway of transmission of salmonellosis—from contaminated animal food to pets to man. The initial source of contamination of the animals was animal feed. Raw poultry viscera should always be presumed contaminated. Such outbreaks can be prevented by thorough cooking of all food from animal sources for pets as well as man.

The etiology of the arthralgia in the 14-year-old boy was probably salmonella-induced polyarthritis. Arthritis is a recognized complication of salmonellosis, particularly infections caused by *Salmonella cholerae-suis* and *S. typhimurium*.[1, 2]

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**HONOR DR. SEDLACEK. . .** Establishment of the Dr. Leo B. Sedlacek Foundation for Alcohol Education has been spurred by the Northwest Iowa Alcoholism and Drug Treatment Unit. Dr. Sedlacek was active in alcoholism prevention in Iowa for many years. The chairman of the IMS Committee on Alcoholism has been designated to serve as chairman of the Sedlacek Foundation.

★

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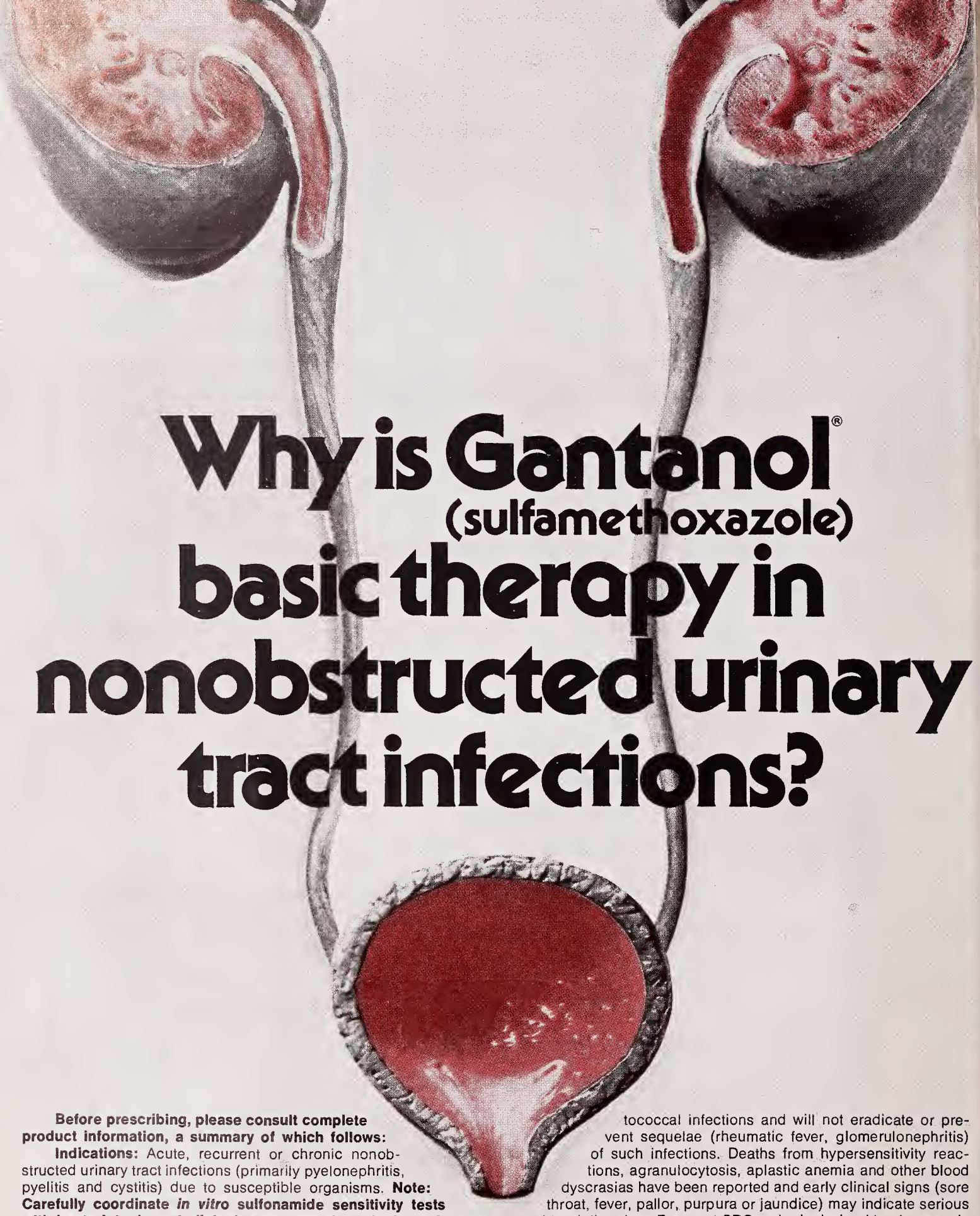

# Why is Gantanol® (sulfamethoxazole) basic therapy in nonobstructed urinary tract infections?

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

# Because it is considered a good choice...

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## (sulfamethoxazole)

### Tablets/Suspension
### (0.5 Gm) (0.5 Gm/teasp.)

pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age** (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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# URGE CONTINUED FAMILY PRACTICE IMPETUS

The need for more physicians to engage in family practice is acknowledged widely and discussed often. In Iowa and nationally. It is gratifying to know that Iowa has made significant progress to this end since the late 1960s.

The medical profession—including the Iowa Medical Society, the Iowa Academy of Family Physicians, the University of Iowa College of Medicine and other components—has furnished important leadership in this quest for more primary care physicians.

What is our status at this point?

Iowa is emerging as a leader nationally in the preparation of family practice physicians. The effort began in earnest five or six years ago and has been in an accelerated status since. The founding of the Department of Family Practice within the University of Iowa College of Medicine occurred in 1970. This was preceded by a feasibility study, headed by Paul M. Seebohm, M.D., who has since directed the College of Medicine's University-based and Statewide Family Practice program development.

In a recent survey of the 110 medical colleges in the country, 49 were found to have family practice programs. Of these, 25 have created full departments but only five have been operational four or more years. This places the University of Iowa among the first five colleges of medicine to establish a Department of Family Practice.

Between 1970 and 1972 three family practice residency programs (Broadlawns in Des Moines, St. Luke's-Mercy in Cedar Rapids and the U. of I. College of Medicine program at University Hospitals and Mercy Hospital in Iowa City) received accreditation from the residency review committee of the American Medical Association. They each had a small number of residents in training at the time.

The FP movement surged forward in 1973-74 to keep pace with or exceed national trends. Additional residency programs (Iowa Lutheran in Des Moines, St. Joseph Mercy Hospital in Mason City, and St. Luke's Mercy Hospital in Davenport) have become operational. Program development is now occurring in Waterloo and Sioux City.

The eight community-based programs are expected to have 103 residents in training by 1976-77. These residents will combine with 23 others in the College of Medicine program to give Iowa 126 family practice residents. This is compared with 12 in 1972/73.

At the undergraduate level, medical student interest and participation in family practice activity is on the rise. The percentage of the Iowa freshman medical class indicating an interest in a family practice career increased from 27% to 51% between 1966 and 1973. The family practice electives for medical seniors, most of which are community-based, were chosen by 47 students in 1972, 70 in 1973, and 103 in 1974.

This undergraduate interest in family practice means one thing: There should be available an adequate number of residency training programs to meet the demand. The residency programs have designated the traditional internship year as the first year of residency and have added two more years to make a three-year residency program.

The competition for places in the residency programs is increasing rapidly. The combined number of applications for family practice residency positions at Iowa City, Broadlawns, Cedar Rapids, Iowa Lutheran and St. Joseph Mercy jumped from 111 in 1973-74 to 300 for 1975-76.

The 65th Iowa General Assembly authorized (effective July, 1973) a biennial appropriation of $925,000 to support the Statewide Medical Education System for training family practice residents. This legislation authorized funding of the educational programs up to 50% of their total cost. However, the appropriation has been sufficient to meet only 22% of the total cost in the 1973-75 biennium.

The next biennium (1975-77) will represent a crucial period for the Statewide Family Practice Residency Programs. Growth is expected in both number of training sites and in the enrollment of training physicians. At the same time community

*(Please turn to page 29)*

# IN THE PUBLIC INTEREST

SCIENTIFIC ARTICLES

# Femoral Neck Fractures: Complications of Internal Fixation

STUART L. WEINSTEIN, M.D.
Iowa City

*High mortality occurs among elderly patients with femoral neck fractures. Early and late complications figure in the picture. Physiologic age is noted as a salient determinant to the treatment outcome.*

FEMORAL NECK FRACTURES occur predominantly in elderly women and carry a high morbidity and mortality rate. More than 80% of the patients are women and more than 80% of the fractures occur in patients over 65 years of age. Twenty per cent of these fractures are nondisplaced.[16, 17, 22] Prior to the advent of the sliding nail and endoprosthesis, only fixed systems were used. These included such devices as the Smith-Peterson nail, Knowles pins and the trifin nail with slide plate. Each method of fixation—fixed system, collapsing system, and endoprosthesis—is fraught with both early and late complications. The general early complications include infection, thrombophlebitis, pulmonary embolism and cardiorespiratory problems. The major late complications of the fixed and collapsing systems are non-union and aseptic necrosis. Radiologic signs suggesting non-union are (1) continued head displacements and (2) nails backing out. Radiologic signs of aseptic necrosis include retention of the original density of the femoral head, and lack of femoral head trabeculae atrophy in three to six months.[20] Clinical signs of aseptic necrosis may not be evident for up to 10 years; although 80% are clinically evident at two years.[23] Primary endoprosthesis has its own unique complications.

The high mortality rate of femoral neck fractures in the elderly—especially in the early postoperative period—occurs regardless of the method of treatment. The national one year survival rate in patients over 65 is approximately 90%. In nondisplaced fractures the mortality rate ranges from 12% to 17.1%; in displaced fractures, from 3% to 27.1%. The mortality rates in patients treated with primary endoprostheses are higher than in the other two modes of therapy, averaging 40%.[1, 6]

There are multiple determinants of complications, both early and late. Major factors are the patient's general health and physiologic age. The older patient population has the highest incidence of femoral neck fractures, and usually an assorted complement of medical problems. In Banks' series, only 97 of 296 patients with femoral neck fractures could be regarded as healthy at the time of

The author is a resident in the Department of Orthopaedic Surgery at The University of Iowa College of Medicine.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JANUARY, 1975.

injury. Of the 296, 137 had a recognizable cardiac lesion.[14] In one series over 90% of the patients with femoral neck fractures, who were institutionalized at the time, had "incapacitating cerebrovascular and cardiovascular disease."[5] In 288 patients evaluated by Hinchey, 249 associated medical illnesses were recorded preoperatively, particularly involving cardiovascular and central nervous systems, in addition to poor general nutritional status (debility and anemia). Forty-seven per cent of these patients were classified as poor medical risks prior to surgery, and failed to survive six months. This mortality was principally a result of preoperative cardiac decompensation, malnutrition and general debility.[2] Postoperative hospital discharge care is another important factor in obtaining good short and long term results.

*Complications of Primary Treatment of Femoral Neck Fractures with Fixed Systems*

The incidence of late complications of this mode of treatment is listed in Table I. With impacted or nondisplaced fractures, the overall incidence of non-union is less than 1%. However, a significant—5.2% to 18%—incidence of aseptic necrosis exists with a minimum follow-up of two years. In a displaced fracture, the incidence of non-union ranges from 8% to 27.6%; aseptic necrosis from 23% up to 68.7%, with an average of 33%. Prior to the advent of the sliding nail, numerous factors had been analyzed as predictors of the incidence of nonunion and aseptic necrosis treated with fixed systems. The degree of comminution plays a role in the incidence of nonunion.[14, 17] The incidence of aseptic necrosis is higher in patients whose Smith-Peterson nail was subjected to multiple drives as opposed to a single drive to achieve placement.[16] Another factor is the type of fracture. The incidence of aseptic necrosis and nonunion increases with the degree of displacement, going from Pauwels I to III and Garden types I to IV.[17] In nondisplaced and impacted femoral neck fractures, the incidence of union increases if internal fixation is used as opposed to no fixation at all (see Table I).[17, 19] The incidence of nonunion and aseptic necrosis is reduced by using a nail and slide plate as opposed to using a nail alone.[14, 17] Finally, the incidence of aseptic necrosis and non-

TABLE I

| | Author | Age | No. Pts.* | Internal Fixation | % Union | % Nonunion | % Aseptic† Necrosis |
|---|---|---|---|---|---|---|---|
| Nondisplaced | Boyd[22] | 68·7(f) 72.9(m) | 68 | Yes | 100 | 0 | 13 |
| | Bently[19] | 72 | 47 | No | 83.7 | 0 | 14 |
| | (Impacted) | | 23 | Yes | 100 | 0 | 18 |
| | Cleveland[16] | 71 | 19 | Yes | 100 | 0 | 5.2 |
| | Banks[14] | 70-80 | 8 | No | 100 | 0 | 9.3 |
| | | | 51 | Yes | 96.6 | 3.4 | |
| | Fielding[10] | 72 | 1 | No | 100 | 0 | 12.1 |
| | | | 32 | Yes | | | |
| Displaced | Goldstein[21] (Pauwels I, II, III) | 65 | 134 | Yes | 79.1 | 20.9 | 23.1 With and without nonunion |
| | Boyd[22] (Pauwels II) | 68.7(f) 72.9(m) | 123 | Yes | 55 | 12 | 33 |
| | Boyd (Pauwels III) | 68.7(f) 72.9(m) | 37 | Yes | 62 | 8 | 30 |
| | Boyd[18] (Pauwels II, III) | | 122 | Yes | 86.5 | 13.5 | 33.6 |
| | Cleveland[16] (Pauwels II, III) | 71 | 63 | Yes | 77.7 | 22.3 | 24.4 |
| | Banks[14] (Pauwels II, III) | 70-80 | 89 | Yes | 72.4 | 27.6 | 33 Without nonunion |
| | Frangakis (Pauwels I, II, III) | | 37 | Yes | 79 | 21 | 38.3 Without nonunion 68.7 With nonunion |

* Follow-up 1 year. † Minimum 2 year follow-up. (f) Female. (m) Male.

TABLE II

| | Author | Fracture Type | Ave. Age | No. Pts. | Nail | % Union | % Nonunion | % Aseptic* Necrosis | % Technical Failure |
|---|---|---|---|---|---|---|---|---|---|
| Nondisplaced | Pugh[8] | Pauwels I | 69 | 2 | Pugh | 100 | 0 | 0 | |
| | Barr[11] | Garden II | 65 | 15 | Vitallium sliding | 93 | 7 | 0 | |
| | Massie[7] | Pauwels I | | 13 | Massie | 77 | 0 | 15 | 7.7 |
| Displaced | Fielding[10] | Pauwels II, III | 73.5 | 30 | Pugh | 90 | 10 | 22 | |
| | Pugh | Pauwels II | 69 | 13 | Pugh | 84.6 | 15.4 | > 3.4 | 14.8 |
| | Pugh | Pauwels III | 69 | 14 | Pugh | 85.7 | 14.3 | | |
| | Barr[11] | Garden III | 65 | 31 | Vitallium sliding | 77 | 23 | 13<br>7 at 2 yr. | 8.3 |
| | Barr[11] | Garden IV | 65 | 29 | Vitallium sliding | 69 | 31 | 21 | |
| | Brown[9] | Garden III | 70 | 26 | Brown | 82 | 4.3<br>Doubtful union<br>4.3<br>Nonunion | 17.4 | |
| | Massie[7] | Pauwels II, III | | 51 | Massie | 84 | 3.9 | 7.8 | 3.9 |

* Followed at least 2 yrs. with union.

union in femoral neck fractures depended upon the position of reduction. There is a higher incidence of aseptic necrosis and nonunion in fractures reduced and fixed in varus or an "over valgus" position, than those that are reduced in the neutral position or in slight valgus.[12, 15]

*Complications Using a Collapsing System*

Results of treatment of fresh femoral neck fractures with sliding nails have been impressive. Many varieties are presently available; all employing three basic principles: proximal fragment fixation, lateral shaft fixation, and impaction of the fracture surfaces allowing for continued impaction if resorption occurs during the healing phase of the fracture.[11, 24] Massie states that three point fixation is needed, fixing the head, calcar and the shaft.

The incidence of late complications in femoral neck fractures treated with collapsing systems can be seen in Table II. Rates of union would be higher if technical failures could be eliminated. However, despite technical error, these union rates were superior to the rates with fixed systems.

In addition to predictors of patients' general health and physiologic age, with a sliding nail the degree of impaction is a factor. Massie feels that incidence of aseptic necrosis and nonunion decreases with increasing impaction, and that lack of impaction causes a protracted healing process with an increased incidence of aseptic necrosis[7] (Weil and Southwick, unpublished data). The rate of union has been found to be a significant factor in the development of aseptic necrosis.[7] Most authors feel that disruption of the blood supply of the proximal fragment occurs at the time of the injury and that healing, union and aseptic necrosis are all dependent on revascularization. The incidence of aseptic necrosis increases proportionally with the lapse of time between fracture and surgery. However, the presence of comminution and the quality of reduction (except varus) seem to have no relationship as to the development of aseptic necrosis in fractures treated with the sliding nail.

Other problems that occur with collapsing systems are collapsing of the nail, which does not differ from rigid fixation and may maintain distraction of the fragments; fracture of the femoral shaft, which can be treated by increasing the number of holes in the plate; and metal failure and nail breakage, which occur rarely.[7]

*Complications with Treatment by Primary Endoprosthesis*

Endoprostheses are primarily used for the patient population with a high average chronologic age, and particularly, a high physiologic age. Patients in this group, treated with primary endoprosthesis, have a higher mortality rate than the other groups discussed. Hawkins recorded a 41% mortality rate in 63 cases with average age of 79, followed for one or more years at the University of Iowa.[1] Hunter reported a 40% incidence of mortality in the first six months.[6] Mor-

tality rates in institutionalized patients treated with primary endoprosthesis are reported as 55.1% in the first six weeks with an average patient age of 81.6 years.[5]

Endoprosthesis eliminates the two major complications of nailing (either with the fixed system or sliding nail), i.e., aseptic necrosis and nonunion. However, this mode of treatment is fraught with its own complications. The early complications are deep infections, superficial infections and wound hematoma, and femoral fractures. Late complications include loosening of the prosthesis, proximal migration, and distal prosthetic migration. Prosthetic dislocations can occur both early and late. The incidence of these complications is seen in Table III.

TABLE III

| | *Hinchey*[2] % | 1° + 2° *Anderson*[4] % | 1° + 2° *Hawkins*[1] % |
|---|---|---|---|
| Deep infection | 1.7 | 0.7 | 2.5 |
| Superficial infection and hematoma | 3.8 | 1.4 | 7.5 |
| Femoral fractures | 0.7 | 4.5 | 6.8 |
| Dislocations | 0.3 | 1.0 | 4.2 |
| Proximal migration | | 15.0 | |
| Distal migration | | 22.3 | |
| Loosening of the stem | | 8.1 | |
| Thrombophlebitis | 1.7 | 1.0 | |
| Incorrect placement | | 0.7 | 3.4 |

Deep infection necessitates removal of the prosthesis thereby nullifying the procedure.[1] It also increases the mortality rate.[2, 5] It is usually manifested by hip pain and toxic symptoms as well as wound exudate; however, in the older age group, these symptoms are often masked. Superficial infections and hematomas will jeopardize the chances of wound healing and increase the liability of deep infection. However, if properly treated, these complications will not jeopardize contingent results.[1, 2, 4] Fractures of the femur seem to have no effect on ultimate results, but increase hospitalization time. Dislocations, when they occur, can be treated by closed reduction and immobilization, without compromising the end result other than by prolonged hospitalization.[1]

Loosening is indicated by pain with weight bearing, rotation and straight leg raising, and the development of a positive Trendelenburg sign. The radiologic signs of loosening are absorption of the femoral neck, deepening of the acetabulum, acetabular sclerosis, radiolucency in the femoral shaft, and motion with traction and rotation. Loosening decreases the chance of a good result and may result in a total failure of the prosthesis.[4]

Distal migration, as evidenced by pain and radiologic evidence of migration occurring early, may not preclude a good result.[4] Proximal migration, however, is a serious late complication. It is evidenced by pain and the radiologic signs of loss of joint space and acetabular sclerosis. Functional results are poor in these patients and they have only an 18% chance for a good or excellent result.[4] Incorrect placement may lead to many of the above complications including loosening, migration both proximally and distally, femoral fractures, and dislocations.

Other factors contributing to poor results with primary endoprosthesis include serious medical diseases: Parkinson's disease, severe arthritis, hemiplegia and mental deficiency. In Hinchey and Day's series, of 37 patients with poor results, 78% had some significant medical disorder.[2] Age is an influencing factor, but neither the time from fracture to surgery, the anesthesia time nor the operative time seem to be significant predictors as to the end results of primary endoprosthesis in the treatment of femoral neck fractures.

## DISCUSSION

Femoral neck fractures in elderly patients carry a high mortality rate regardless of the specific treatment. Each mode of primary treatment has its attendant early and late complications. The incidence of nonunion has been markedly decreased by the use of collapsing systems as opposed to fixed systems, however, aseptic necrosis remains a significant problem with both. In nondisplaced or impacted femoral neck fractures the incidence of nonunion is low; however, the use of fixation (either with fixed or collapsing systems) as opposed to no fixation, can eliminate this complication. Endoprosthesis eliminates the complication (s) of aseptic necrosis and nonunion, but its use attends complications unique to it.

The salient factor in the outcome of femoral neck fractures is the patient's physiologic age.

## REFERENCES

The references noted in this article may be obtained from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

***IMPORTANT INFORMATION:*** *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

*Indications:* Lomotil is effective as adjunctive therapy in the management of diarrhea.

*Contraindications:* In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

*Warnings:* Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

*Usage in pregnancy:* Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

*Precautions:* Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

*Adverse reactions:* Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

*Dosage and administration:* ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

*Overdosage:* Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

*Dosage forms: Tablets,* 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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# IOWA FOUNDATION FOR MEDICAL CARE

**PLANNING CONTRACT STATUS . . .** The Iowa Foundation for Medical Care has completed its initial plan for assuming PSRO conditional activities in Iowa. The plan draft was finalized near the end of December. It contains a full explanation of the approach the IFMC expects to follow in meeting PSRO review requirements.

**PILOT DEMONSTRATIONS . . .** Three pilot programs to test comprehensive quality assurance techniques in the smaller hospital setting are a new joint undertaking of the IFMC and the Iowa Hospital Association. The project is funded by the Iowa Regional Medical Program. The three approaches include: 1) small hospital working with large hospital—Humboldt/Fort Dodge; 2) three small hospitals working together—hospital sites being selected; and 3) small hospital working alone—Pella. The PSRO law allows delegation of review authority to the local institution where it is felt the review is being performed effectively.

**PSRO INFO SEMINARS . . .** Ten November and December seminars on the PSRO law and its implications for hospitals and medical staffs have been presented by the IFMC and the IHA. Emphasis was placed on the availability of consulting services to aid in developing comprehensive quality assurance programs.

**COUNTY MEETINGS . . .** Thirty IFMC meetings with county medical societies have occurred this fall. An estimated 80% of Iowa's physicians were briefed at these sessions. Current Foundation activities were summarized with emphasis on the anticipated PSRO role. Foundation officers will gladly meet with county societies to present information.

**STANDARDS OF HEALTH CARE . . .** Presidents of the major specialty organizations in Iowa have received a letter from IFMC President K. E. Lister, M.D., inviting revisions or additions to the Standards for Health Care.

**PEER REVIEW CASES . . .** Over 1,000 peer review cases were submitted to the IFMC in 1974. Most involved fee questions raised by a physician or an insurance company.

# Carcinoma of the Rectum

W. H. DE KRAAY, M.D.,
G. C. BLOME, M.D.,
K. E. LISTER, M.D., and
H. L. WORMHOUDT, M.D.
Ottumwa

*A 15-year experience of treating carcinoma of the rectum by abdominal perineal resection is compared with instances where preoperative radiation has been used. A 5-year follow-up study has been undertaken.*

Recent reports from the Veterans Administration collective study group and the University of Oregon have described preoperative radiation for carcinoma of the rectum prior to abdominal perineal resection. These reports prompted the authors to study the results of their abdominal perineal resections for carcinoma of the rectum to assess the effectiveness of this form of treatment.

According to a recent cancer survey published by the University of Iowa,[1] 450 carcinomas of the rectum are diagnosed annually in Iowa. Obviously, any procedure according a good result in these diagnoses is worthy of pursuit.

This study will (1) present the results of our experiences with abdominal perineal resection, and (2) will correlate our results with those obtained with preoperative radiation by the University of Oregon and the Veterans Administration material.

## MATERIAL

All patients with a diagnosis of carcinoma of the rectum treated by abdominal perineal resection in the 15-year period between 1952 and 1967 were included in the study. This provided at least a 5-year follow-up on all patients.

The authors are engaged in the practice of surgery in Ottumwa, Iowa. This paper was presented at the Iowa Academy of Surgery September 13, 1974.

## SEX AND AGE

There were 112 patients with 66 males and 46 females in the study. The majority of patients were in the 60 to 69 age group (34%).

## SURVIVORSHIP

Fifty-six of the 112 patients had no lymphatic involvement and 56 patients had lymphatic involvement by the cancer. Only 12 of the 56 patients with lymphatic involvement or 21% survived 5 years, while 34 of the 56 patients or 59% without lymphatic involvement survived 5 years. The overall total of both categories was 46 patients or 40% overall 5 year survival, however, 15 patients subsequently developed a recurrence resulting in a cancer free five year survival of only 31 patients out of 112 patients or 28%.

## HOSPITAL MORTALITY

Five patients died within 30 days of surgery, for a 4% hospital mortality. The causes of death are listed in Table III.

TABLE I

112 ABDOMINAL PERINEAL RESECTIONS

| Age | | % |
|---|---|---|
| 20-29 | 1 | 1 |
| 30-39 | 2 | 2 |
| 40-49 | 6 | 5 |
| 50-59 | 25 | 22 |
| 60-69 | 37 | 34 |
| 70-79 | 35 | 31 |
| 80-89 | 6 | 5 |
| Male—66 | Female—46 | |

TABLE II

SURVIVORS

| | No. of Patients | 5 Year No. | 5 Year % | 5 Year Cancer Free No. | 5 Year Cancer Free % |
|---|---|---|---|---|---|
| Positive lymph ..... | 56 | 12 | 21 | 6 | 9 |
| Negative lymph ..... | 56 | 34 | 59 | 25 | 41 |
| Total ..... | 112 | 46 | 40 | 31 | 28 |

TABLE III

30-DAY HOSPITAL MORTALITY

| | |
|---|---|
| Cardiovascular accident | 1 |
| Coronary occlusion | 1 |
| Upper gastrointestinal hemorrhage and renal failure | 1 |
| Perineal hemorrhage | 1 |
| Liver failure (metastases at surgery) | 1 |
| Total | 5 |
| | 4% |

## OTHER CARCINOMAS

The propensity of patients with one carcinoma to develop other carcinomas is illustrated in Table IV.

Two patients had a previous carcinoma of the cecum. One patient had a small bowel carcinoma 4 years postoperatively and carcinoma of endometrium prior to the abdominal perineal resection. One patient had an ileo-colectomy 5 years previously for polyposis. Two patients developed carcinoma of the breast postoperatively, one of which was found 7 years postoperatively and the patient died of recurrent rectal carcinoma. The other occurred 12 years postoperatively and the patient is alive and well. One patient developed carcinoma of the prostate with skeletal metastases 12 years after his abdominal perineal resection.

## COMPLICATIONS

Perforation of the colostomy with subsequent abscess formation occurred in seven patients.

TABLE IV

OTHER CARCINOMAS

| | |
|---|---|
| Polyposis with ileo colostomy | 1 |
| Carcinoma of the lung (11 years post-op.) | 1 |
| Carcinoma of the bowel | 3 |
| Carcinoma of the prostate | 1 |
| Carcinoma of the breast | 2 |

One patient died from peritonitis. All these occurred at home during routine irrigations. Most patients preferred to irrigate their colostomy every morning rather than have a movement unexpectedly.

*Stomal stenosis* requiring revision occurred in 4 patients. Most of these occurred prior to maturing colostomy at time of surgery.

*Bowel obstruction* occurred in 4 patients requiring surgery for correction of obstruction.

A urinary fistula developed in two patients postoperatively, both closed spontaneously.

TABLE V

COMPLICATIONS

| | |
|---|---|
| Perforated colostomy (4 months to 10 years postoperatively) | 7 |
| Stomal stenosis | 4 |
| Bowel obstruction (18 days to 6 years postoperatively) | 4 |
| Urinary fistula | 2 |

## DISCUSSION

In comparing our results with others in Table VI the 50% lymphatic involvement in our series is higher than usual, but the 40% overall 5 year survival is typical for the disease. Although our 59% 5 year survival without node involvement is higher than usual, our 21% 5 year survival with positive nodes is lower than usual, resulting in the 40% overall 5 year figure.

In trying to evaluate the effects of preoperative irradiation on carcinoma of the rectum, the following criteria were considered between the controls and treated groups:

(1) The percentage of lymph node involvement in the resected specimens.

(2) Five year survivals.

(3) The percentage of perineal recurrences.

In the V.A. study, 5 year survival in the control group was 27% versus 40% in the irradiated

TABLE VI

ABDOMINAL PERINEAL RESECTIONS

| | No. | % Positive Lymph | Overall 5 yr. Survival % | Neg. Nodes 5 yr. Survival % | Pos. Nodes 5 yr. Survival % |
|---|---|---|---|---|---|
| (2) Glenn | 422 | | 40 | 35 | 24 |
| (3) Reynolds | 104 | 36 | 40 | 48 | 26 |
| (4) Gilbertson | 193 | 43 | 43 | 46 | 27 |
| Ottumwa | 112 | 50 | 40 | 59 | 21 |
| (5) V.A. | 208 | 43 | 27 | 37 | 23 |

TABLE VII

| | No. of Patients | | Perineal Recurrence % | 5 Year Survival % | Positive Nodes % |
|---|---|---|---|---|---|
| V.A. Hospital | 208 | 2000 Rads. | — | 40 | 27 |
| (6) University of Oregon | 50 | 5000 Rads. | 20 | 65 N.E.D. | 20 |

group. This was not a significant change over the results depicted in Table VI which showed an average 5 year survival of 40%. The University of Oregon has a 5 year follow-up with no evidence of disease of 65%.

Table VII reveals that the percentage of involved lymph nodes decreased to 27% in the V.A. Hospital group and to only 20% in the University of Oregon series. This is a considerable decrease from the 50% node involvement found in our series.

TABLE VIII

ABDOMINAL PERINEAL RESECTIONS

| | % |
|---|---|
| *Pelvic Recurrences* | |
| (7) Morson | 15 |
| (8) Bacon | 17 |
| (9) Butcher | 19 |
| Ottumwa | 11 |
| *Preoperative Radiotherapy* | |
| University of Oregon 50 Patients 5000 Rads. No Pelvic Recurrence | |

Pelvic recurrences were significantly decreased by preoperative radiotherapy. The V.A. study did not investigate pelvic recurrences, but the University of Oregon study had no pelvic recurrence in the 50 patients treated with 5000 rads. These results were presented at the American College of Surgeons meeting in Chicago, October 1973. As noted in Table VIII the usual pelvic recurrence rate varies between 11% and 19%.

At the present time the V.A. study group and others are using 5000 rads in preoperative irradiation for carcinoma of the rectum. Wound or perineal healing has not been a problem. The results should be followed with interest by all of us who are involved in the treatment of this disease.

Our experience with abdominal perineal resections in patients over 80 years of age is listed in Table IX. Of the 6 patients having an abdominal perineal resection, 4 died of recurring cancer, 1 to 3 years postoperatively. One patient died of other causes 2½ years after surgery and one patient is alive and well 10 years postoperatively. Our experience would indicate that an abdominal perineal resection in our patients in the 80 and over age group provided satisfactory palliation and even cure.

TABLE IX

ABDOMINAL PERINEAL RESECTIONS IN PATIENTS OVER 80

| | | |
|---|---|---|
| M. E. | (89) | Died 2½ years postoperatively, no recurrence. |
| B. D. | (81) | Died 1 year postoperatively, pelvic recurrence. |
| N. M. | (81) | Died 1½ years postoperatively, lung metastases. |
| T. W. | (81) | Died 2 years postoperatively, lung metastases. |
| O. O. | (80) | Alive and well, 10 years postoperatively. |
| F. L. | (80) | Died 3 years postoperatively, lung metastases. |

## SUMMARY

Our experience with carcinoma of the rectum treated by abdominal perineal resection over a 15-year period has been presented. Evaluation of our results with other published reports and particularly those which have used preoperative radiation has been made.

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# An Unusual Cause of Carpal Tunnel Syndrome

O'NEIL ENGERON, M.D., and
JAMES O. STALLINGS, M.D.
Des Moines

*Surgical removal of a multilobular lipoma from the carpal and mid-palmar space is reported. When treating this disorder the authors urge thorough exploration of the carpal tunnel.*

CARPAL TUNNEL SYNDROME is a very common condition which can be caused by any process which results in compression of the softer median nerve in the relatively unyielding carpal canal.[1] Sir James Paget[2] described the first case in 1865. We wish to present a most unusual cause of carpal tunnel syndrome.

## CASE REPORT

A 53-year-old right handed male carpet layer was found to have a 6 by 5 by 3 cm soft, nontender, nontransilluminating mass in the left mid palm (Figure 1). Slow enlargement occurred over eight years with an associated decrease in mechanical function due both to its size and because of numbness and tingling of the volar aspect of the thumb, index and middle fingers. X-rays of the hand revealed a radiolucent defect in the mass in the left palm. Nerve conduction studies revealed prolonged conduction time in the median nerve in the area of the palmar mass.

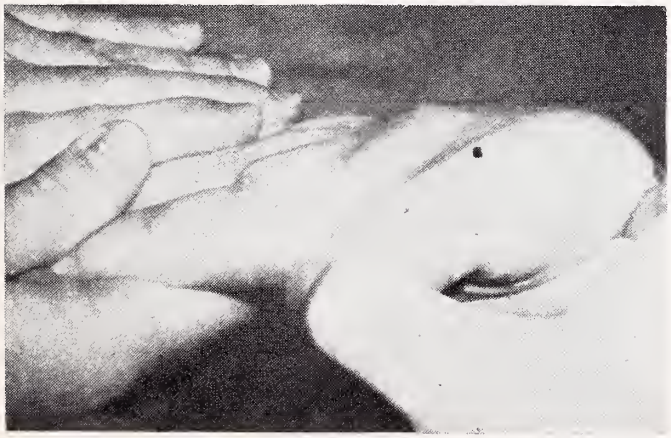

Figure 1. Large lipoma of the left palm causing compression of the median nerve.

At operation, using a pneumatic tourniquet, a modified carpal tunnel incision was made taking great care to preserve the palmar cutaneous branch of the median nerve. The transverse carpal ligament was divided and the median nerve was seen to be stretched around a multilobular lipoma (Figure 2). The lipoma extended well

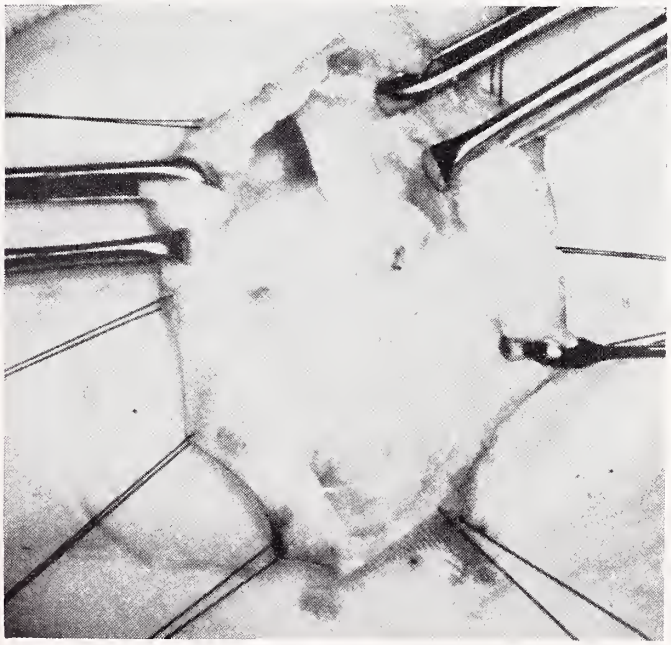

Figure 2. The median nerve is severely compressed by the lipoma and actually invades the substance of the lipoma.

This paper is submitted by the Surgery Service at the Veterans Administration Hospital in Des Moines, Iowa. Dr. Engeron was a surgical resident and Dr. Stallings is a consultant in plastic surgery.

Figure 3. The branches of the median nerve entwine around the multilobular lipoma.

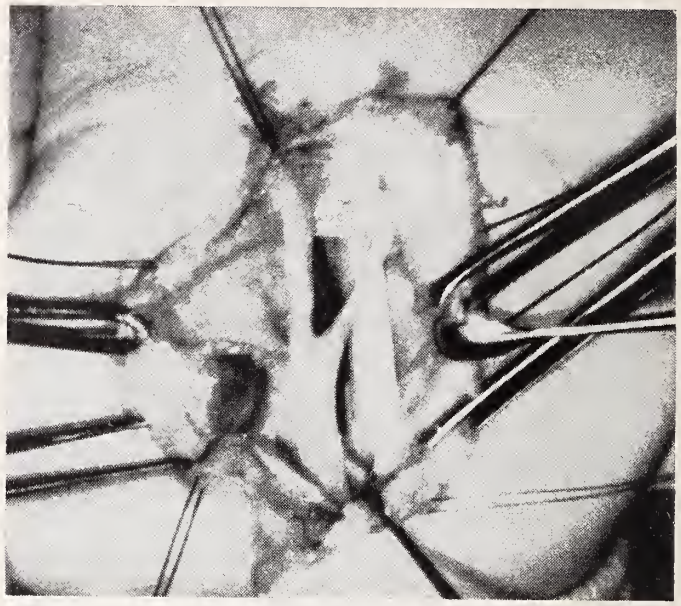

Figure 4. All the lipoma has been removed without damage to the median nerve or other structures in the carpal tunnel.

into the carpal and the mid-palmar space (Figure 3). It was possible to remove the lipoma leaving the median nerve and all other contents of the carpal tunnel intact (Figure 4). The carpal tunnel was explored and found to contain no other pathology. The flattened median nerve was neurolysed with sharp dissection under magnification. At an early point in the postoperative period all numbness and tingling disappeared and a full range of motion was present. There has been no sign of recurrence of the neoplasm after one year.

## DISCUSSION

There are many causes of the carpal tunnel syndrome. Some of the etiologies have been: aberrent origins of the lumbrical muscles;[3] thrombosis of the median artery; bee stings;[4] systemic diseases such as acromegaly,[5] amyloid disease, gout and rheumatoid arthritis; tumors arising in the carpal canal, ganglion being the most frequent; and fracture of the wrist with dislocation of the bony fragments into the carpal tunnel.

Although lipomas are common elsewhere in the body they are relatively rare in the hand and have been estimated to comprise less than 5% of all benign tumors.[6] Rodriguez and Phalen[7] in 1970 reported that less than 50 lipomas of the hand had been reported in the surgical literature. Mason[8] divided lipomas into subcutaneous and subfascial types depending on their location with regard to the palmar aponeurosis. As in the present case, the subfascial types tend to be larger and multinodular. They possess a definite capsule and tend to entwine around surrounding structures and may even extend through the interosseous muscles to the dorsum of the hand.[9] They may be differentiated preoperatively from cysts by their lack of transillumination.

Because of the many causes of carpal tunnel syndrome we strongly recommend that every surgeon thoroughly explore the carpal tunnel in every case. Adequate exposure under a pneumatic tourniquet is very helpful to allow complete division of the transverse carpal ligament and permit complete inspection of the carpal tunnel.

## SUMMARY

An unusual cause of carpal tunnel syndrome, a large lipoma, is presented. It is suggested that all surgeons treating this disorder completely explore the carpal tunnel while utilizing a pneumatic tourniquet.

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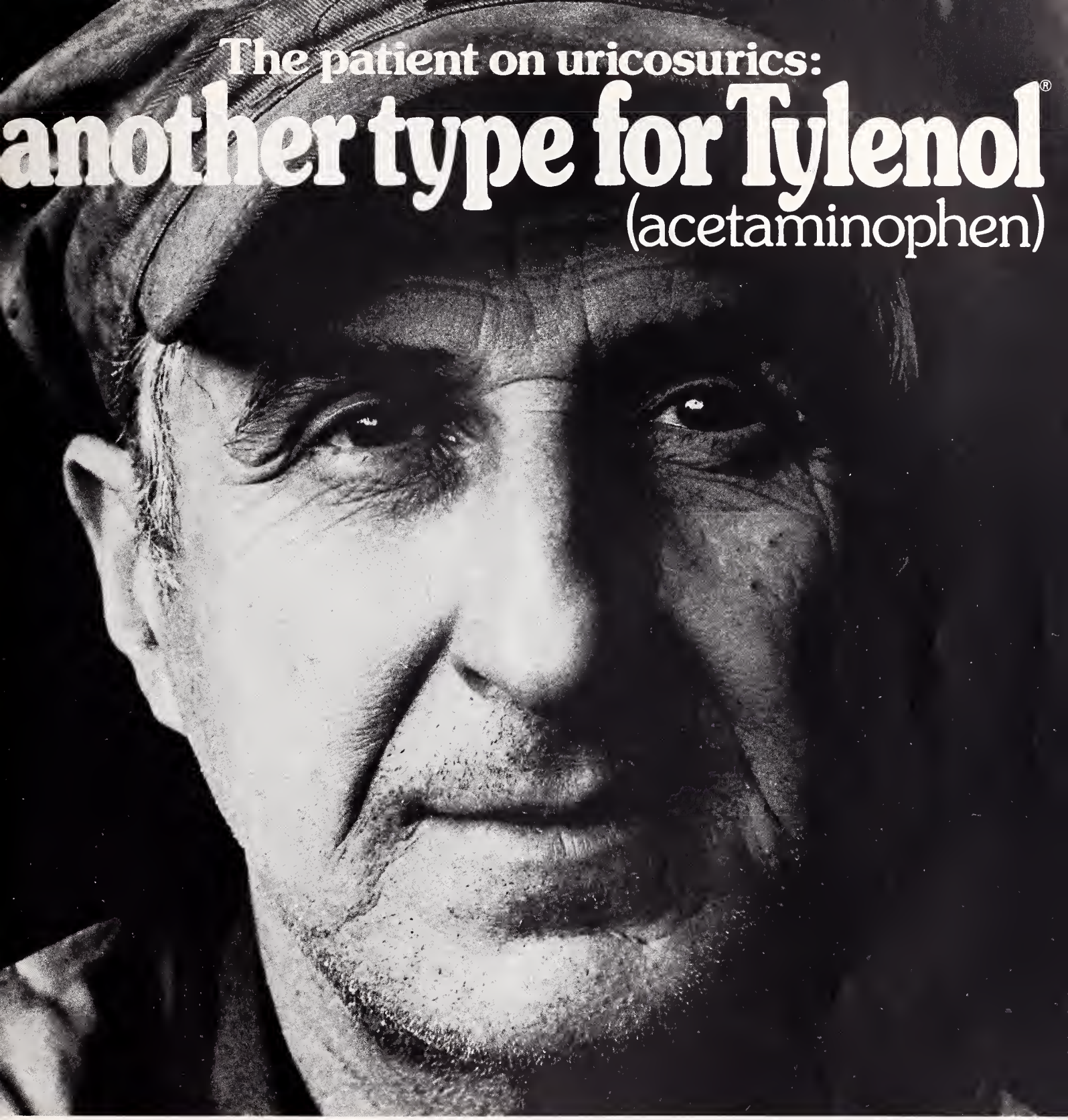

# The patient on uricosurics: another type for Tylenol® (acetaminophen)

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**References: 1.** Martin, E.W., et al., ed.: Hazards of Medication, Philadelphia, J.B. Lippincott Co., 1971, p. 511. **2.** Seegmiller, J.E.: Med. Clin. North Amer. 45:1259-1272 (Sept.) 1961.

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# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## A NEW YEAR

January is a unique month in our way of life. It provides the stimulus to look forward as well as to the past. Like the two faces of Janus we look both ways, but more to the future. As we look ahead we must take stock of ourselves and lay down guidelines for our conduct. The human being is most interesting because of the values by which he lives. Our lives are guided consciously or unconsicously by moral precepts.

I would like to borrow from the personal creed of Robert Louis Stevenson to raise some thoughts for the future. We must make the best of our circumstances. No one has a right to everything. All of us have some sorrow intertwined with the gladness of life. We must try to overcome the tears with the sunshine of laughter.

It is impossible to please everybody. It is impossible to be pleased with yourself all the time. We must take stock of ourselves, be ourselves, but not take ourselves too seriously. If we keep busy we have no time to be unhappy. To be busy does not mean that no time is taken for fun. Stevenson loved the sea and did much of his writing while on cruises among the Pacific Islands. Though he lived but a short 44 years, Stevenson produced much for his fellow man.

Another man produced much in a short span of life. Peter Marshall served as chaplain of the U. S. Senate. His biography, A MAN CALLED PETER, is the basis for a successful movie. He once said, "The measure of life, after all, is not its duration, but its donation." Marshall, too, found time for fun in his busy 46 years of life. Fun can be worth the time. It is not only watching television, or spending a night drinking highballs. Life can be enriched by reading about far-off places when they cannot be visited, writing to absent friends when they cannot be present, and enjoying the wondrous sight of a sunset, or the surf breaking over a rocky shoreline, or a child happily at play in a park.

Time is for living; the future is time unmeasurable. Look forward as the new year commences and enjoy life. Be not totally burdened by the quest for monetary fortune, for the man who is truly rich is the one who has taken time to smell the roses, listen to the birds, and appreciate life for what it truly is.

Happy New Year!—M.E.A.

## WEIGHT-REDUCTION WEIGHED

Investigations of weight reduction "clinics" are under way. Overweight persons are flocking to "clinics" which advertise the use of human chorionic gonadotropin injections to reduce weight. This substance is made from the urine of pregnant women. It does not work in the treatment of obesity. Obviously, concomitant advice, e.g., a 500-calorie-a-day-diet, may produce the desired result.

The AMA and the FDA agree there is no proven usefulness of H.C.G., and consequently an ethical question is raised when any physician utilizes this approach to treat his patients. Legal questions also may be raised. Another area of concern, ethically and legally, is the association of physicians within lay-directed clinics where this activity is performed by lay persons.

The method is dubious; the substance injected is unproven; the matter is under sharp scrutiny. Any physician so involved would be well-advised to re-evaluate his position and involvement. —M.E.A.

# Refresher Course For the Family Practitioner

The 1975 Refresher Course for the Family Practitioner will occur in Iowa City February 10 to 14 under sponsorship of The University of Iowa College of Medicine and the Iowa Academy of Family Physicians.

The course is accredited for 29 hours by the American Academy of Family Physicians and for Category I credit toward the AMA Physicians' Recognition Award. Full information is available from the Office of Continuing Medical Education, U. of I. College of Medicine, Iowa City, Iowa 52242.

The "In-House Conference" Monday, February 10, is optional and affords an opportunity to visit the clinical departments. The Iowa-Ohio State basketball game will be available.

Topics to be considered on the following three days include:

## TUESDAY, FEBRUARY 11

Urinary Tract Infections in Children
General Management of Acute Poisoning
Bedside Diagnosis of Stroke
Hypertension Questions and Answers
Drugs Against Cancer
Plastic Surgical Techniques for Wound Closure
What the Laparoscope Can Accomplish
Ulcers, Antacid, and Other Gut Issues
Property Care of the Patient with a Urinary Catheter
Untoward Reactions from Drugs
Vasectomy: Techniques, Questions and Answers
Physical Therapy Techniques for Common Problems
Blood Gases and IPPB in the Small Hospital

## WEDNESDAY, FEBRUARY 12

Carcinoembryonic Antigen
Neck Injuries in Football
Appropriate Use of Antibiotics in Children
Statewide System for Emergency Medical Services
Family Planning, Contraception and Abortion
The Patient in Shock
New Materials and Methods for Casts and Braces
Rehabilitation after Heart Attack
What Does "Heartburn" Really Mean?
Applications of Ultrasound Techniques
Coping with Toxemia
Gall Bladder Disease
Poisons All Around Us—Of Mice and Men

## THURSDAY, FEBRUARY 13

Cardiac Emergencies
The Glaucomas—Early Diagnosis and Management
Cerebral Ischemia
Use of Freezing, Curet, Blade and Hyfrecator for Common Skin Lesions
Toxic Agents and Cancer in Iowa
Pills to Dissolve Gallstones
Prostatitis and Prostatosis
Management of Premature Labor
Newest Thoughts about Hyaline-Membrane Disease
Thrombosis—Its Cause and Control
Managing Acute Respiratory Failure
Dx and Rx of Gynecologic Infections
ENT in the Office

## FRIDAY, FEBRUARY 14

What Constitutes an Ocular Emergency
The Importance of Hyperalimentation
Recognizing and Managing Anaphylaxis
New Developments in Prostatic Cancer
Managing Acute Alcoholic Intoxication
Are You Using Digitalis Safely
Proper Use of Cromolyn Sodium in Asthma
Cardiology
Practical Problems in Genetic Diseases
Management of Atopic Dermatitis in Children
Antibiotics and Venereal Infections
Colonscopic Examination of the Entire Colon

## In the Public Interest

*(Continued from page 16)*

hospitals must confront local budget restrictions. How then does this important effort go forward? It is the hope of the medical profession that a state appropriation will be forthcoming to permit funding closer to the authorized percentage (50%) of support.

These family practice programs would not have reached their present favorable point without substantial support from the communities in which they are located. The physicians involved have given many hours of instruction to the resident trainees, principally by inviting them to participate in the care of their patients. Likewise, hospital administrators and members of hospital boards have sponsored and financially supported the development of programs and facilities.

In July 1974, seven family physicians graduated from the programs of the Statewide System. These are the first to receive the three years of formal training in Family Practice in Iowa. As the programs mature, this number will reach about 50 family physicians a year, a number that should start to create an improved medical manpower picture in Iowa.

The Iowa Medical Society will urge members of the Iowa General Assembly to support the 1975-77 biennial budget asking for this important program.

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## THE WRITER'S TASK, AND MINE

Thackeray has said that a writer's task is "to make the new familiar, and the familiar new." To judge how successful *he* was, just ponder the nine words that complete that last sentence!

Educators generally, and medical educators among them, believe they're engaged in making the new familiar. Listen: "I know a new fact and can perform a new skill. Pay attention to me, all you who do not know my fact and my skill, and I shall transmit them to you, that the new will become familiar to you."

The same thing happens in continuing medical education, and needs to. But something else must happen with learners who are themselves skilled practitioners. He who would teach them must also make the familiar new. He must reinforce what is already known, to make it even more secure. He must invigorate his student by enlivening his presentation with fresh phrasing, recent insights, revealing analogies and instructive examples, so that old information and standard techniques gain renewed luster and refurbished significance. Let each practitioner be helped to grow by an increment of understanding and a zeal to perform tasks that had grown stale and automatic.

An effective experience in continuing medical education should awaken the sense of curiosity, polish the skills of observation and logic, and satisfy the hunger for mental stimulation. It can remind the practitioner that each patient brings a new problem to solve, a puzzle to decode. And because continuing education cleans and oils the intellectual machinery, it prepares and encourages the receptive practitioner to synthesize his experience into new medical knowledge. Continuing education provides passive and active stretching of the mind. Like physical exercise, it is needed regularly.

Dr. Caplan is Associate Dean, Continuing Medical Education at The U. of I. College of Medicine.

# Continuing Education Courses & Conferences

*Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.*

| | |
|---|---|
| Jan. 8 | Ophthalmology Clinical Conference |
| Jan. 20-23 | Cardiology Today |
| Jan. 21 | Cancer Seminar—Tumor Associated Antigens |
| Feb. 5 | Ophthalmology Clinical Conference |
| Feb. 11 | Sociological Perspectives of Cancer |
| Feb. 11-14 | Refresher Course for the Family Physician |
| Mar. 5 | Diet Therapy U.S.A. |
| Mar. 5 | Ophthalmology Clinical Conference |
| Mar. 11 | Viral Etiology of Cancer |
| Mar. 24-27 | Cardiology Today |

## FAMILY NURSE PRACTITIONERS

Now three months into motion is an Iowa "pilot project" to prepare six registered nurses to function as family nurse practitioners (FNP) in a satellite clinic setting.

This experiment in the use of health manpower is co-sponsored by the Iowa Medical Society and the Iowa Hospital Association. Its financial support is coming in the form of a $70,390 grant from the Iowa Regional Medical Program.

The six RN's are now engaged in a rigorous training plan which has them rotating between actual on-site indoctrination under the supervision of their preceptor physician and formal instruction at the University of North Dakota. In September 1975, upon successful completion of the program, the six will receive family nurse practitioner certificates. At that time the FNP's will be prepared to work in a satellite clinic under guidance and direction of the sponsoring or employing physician.

The Iowa physicians serving as preceptors are George Fieselmann, M.D., Spencer, James Kimball, M.D., Osceola, James Shehan, M.D., Red Oak. Larry Richards, D.O., Altoona, Sam Williams, D.O., Maquoketa, and Floyd Jones, D.O., Shenandoah.

Sister Mary Brigid of the Hospital Association is coordinator of the project.

The nurse participants have been selected on the basis of having had the necessary previous education, training and experience. With the additional year of training they will possess the competence to function, on a trial basis, in this unique health care role. Stress throughout the program is being placed on the team concept with the FNP acting as an important team member under the supervision of the physician.

The six preceptors have indicated they will employ the FNP's to work at satellite clinics near their offices after they receive their certificates.

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**TV SERIES . . .** Television health education series entitled "Medix" is being offered by Burroughs Wellcome Company to Iowa TV market. IMS Board has approved no-cost co-sponsorship of series and has authorized use of concluding line reading, "brought to you . . . in cooperation with your local and state medical societies."

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# The Pain Phone

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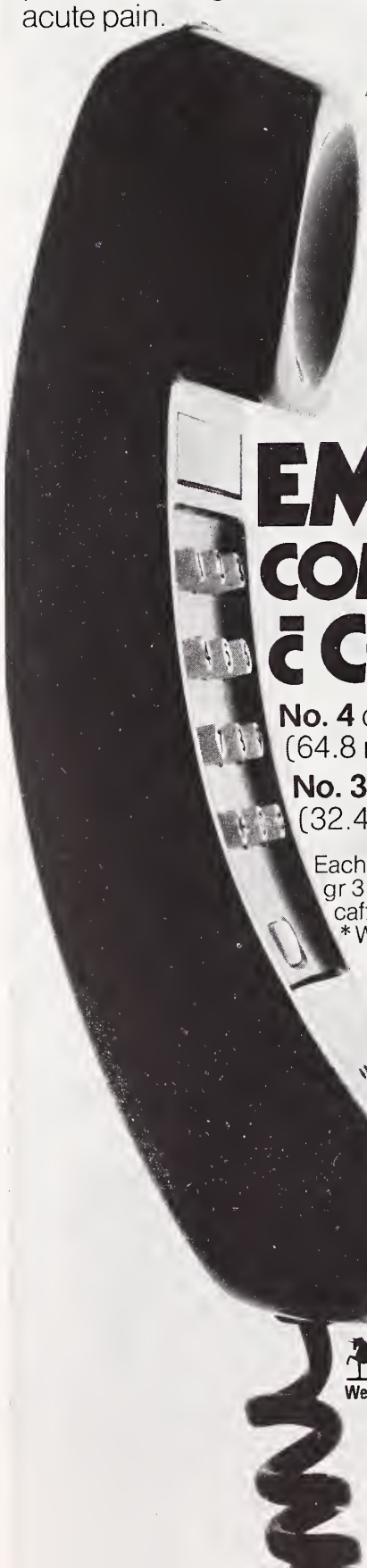
† The exceptions: Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia.



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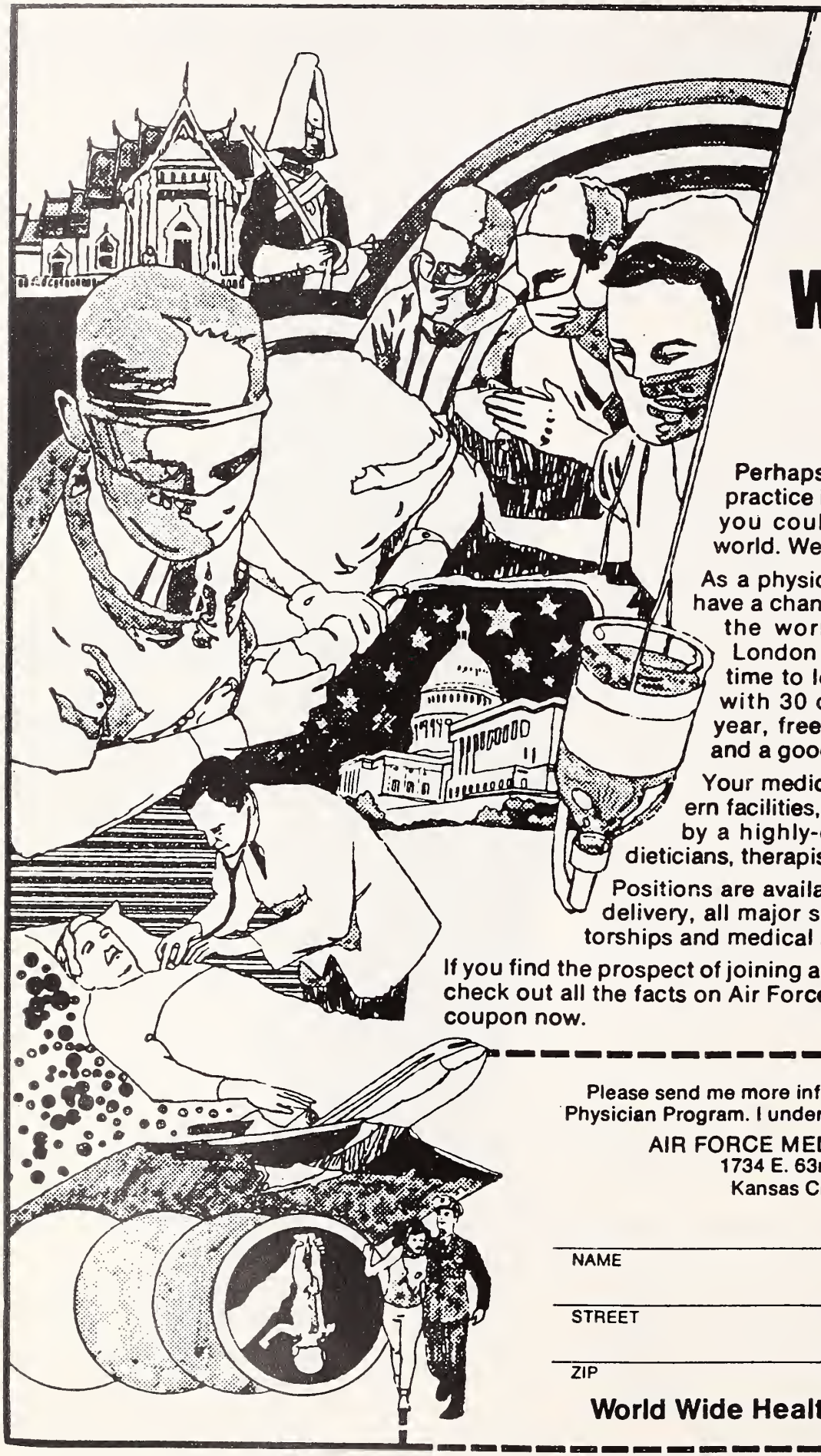

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# About IOWA Physicians

Eight Fort Dodge community physicians participated in a recent program on emergency care for nursing personnel: **Drs. Gary L. LeValley; Dr. Jesse Landhuis; Dr. Leroy K. Berryhill; Dr. Donald Bock; Dr. D. L. Lulu; Dr. William Robb; Dr. Herbert Kersten;** and **Dr. Roy O. Sebek.** The program is being conducted by the Adult and Continuing Education Division of Iowa Central Community College. . . . **Dr. Richard M. Caplan,** associate dean, Continuing Medical Education, U. of I. College of Medicine, was guest speaker at recent meeting of Midwest Regional Group of Medical Library Association at Iowa City. His topic: "Health Sciences Communication and Continuing Education at the Grassroots."

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**Dr. Ronald E. Lemmons,** surgeon, has joined the staff of Holy Family Hospital in Estherville. Dr. Lemmons is graduate of Tulane School of Medicine. He interned and had a surgical residency at Touro Infirmary in New Orleans, La. He served at the University Clinic in Lubbock, Texas, and was on the teaching staff of Texas Tech Medical School. . . . **Dr. David A. Culp** has been named Head of the Department of Urology at U. of I. College of Medicine. Dr. Culp received the M.D. degree at Jefferson Medical College. Following two Army years, he joined the U. of I. faculty in 1950. Dr. Culp follows **Dr. Rubin Flocks,** immediate past president of IMS, as Head of the Urology Department. . . . **Dr. Joseph Brunkhorst,** Iowa Falls, spoke on "Reach to Recovery" at recent seminar on breast cancer at Ellsworth Community College in Iowa Falls. . . . **Dr. Nelson H. Chesney** will join Winterset Medical Associates in medical practice following completion of his internship next year. Dr. Chesney is a 1974 graduate of U. of I. College of Medicine and is interning at Maricopa County Hospital in Phoenix, Arizona.

**Dr. Otto N. Glesne,** Fort Dodge, was one of six former St. Olaf College athletes recently inducted into the College's athletic hall of fame. Dr. Glesne earned football letters in 1918, 1919 and 1920 and was team captain during his senior year. He is a former president of Iowa Medical Society and North Central Medical Conference. . . . **Dr. Harold Moessner,** Oakdale, was a guest speaker at annual meeting of Southeastern Iowa Commission on Alcoholism. Dr. Moessner spoke on "Working Together for the Alcoholic." . . . **Dr. George Winokur,** professor and head of psychiatry, U. of I. College of Medicine, has been named the Paul W. Penningroth Professor of Psychiatry. The professorial chair was established by the Penningroth Foundation of Atlanta, Ga., and honors the late Dr. Penningroth, 1922 graduate of U. of I., who was a prominent national and international educator in the treatment and care of emotionally disturbed children. Dr. Winokur has also been recognized nationally and internationally for his research in mental illnesses. . . . **Dr. John Hess, Jr.** has closed his medical practice in Des Moines to accept a teaching position in the Family Practice Residency program at Broadlawns Hospital.

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The following physicians have recently joined Sioux City doctors—**Dr. F. John Kissel,** family practitioner, is associated with **Dr. John Roberts.** Dr. Kissel received the M.D. degree at Creighton University Medical School and served his internship and residency at Creighton Memorial Hospital in Omaha, Nebraska. **Dr. L. Douglas Oss,** dermatologist, has joined **Drs. W. C. Ziebell** and **R. F. Godwin.** Dr. Oss received the M.D. degree at U. of I. College of Medicine, served his internship at Gunderson Clinic and Lutheran Hospital in LaCrosse, Wisconsin, and his residency at University Hospitals in Iowa City. **Dr. Alan Pechacek,** orthopedist, is associated with **Drs. E. M. Mumford, K. M. Keane,** and **D. G. Paulsrud.** Dr.

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Pechacek received the M.D. degree at U. of I. College of Medicine, interned at Parkland Memorial Hospital in Dallas, Texas, and took his residency at University of Texas Southwestern Medical School Affiliated Hospital in Dallas. . . . **Dr. George A. Richards,** formerly of Knoxville, and **Dr. Armando Ponce,** formerly of Milwaukee, Wisconsin, have begun residencies in psychiatry at Mental Health Institute in Cherokee. Dr. Richards, a native of Bolivia, received the M.D. degree at University of Guadalahara, and interned at Regina General Hospital, Regina, Saskatchewan. Prior to entering medical school, Dr. Richards was a Spanish teacher in the Knoxville School System. Dr. Ponce received the M.D. degree at University of Santo Tomas in the Philippines, and interned at Iowa Lutheran Hospital in Des Moines. . . . **Dr. C. A. Nicoll,** Panora, has retired from active medical practice. He will continue to serve as a consultant at the Panora Health Center. Dr. Nicoll has been in Panora since 1932.

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**Dr. Walter Kopsa,** Tipton, is a new member of Iowa Regional Advisory Group. He was so named at recent Iowa Regional Medical Program annual meeting in Des Moines. . . . **Dr. Walter Eidbo,** Des Moines, was recent guest speaker at meeting of Casson Ostomy Group in Des Moines. . . . **Dr. John R. Hornberger,** Manning, is new president of Carroll County Medical Society; **Dr. James P. Jensen,** D.O., is vice president; **Dr. Eleanor Roverud,** secretary-treasurer; **Dr. James M. Tierney,** delegate; and **Dr. Charles E. Schaefer,** alternate delegate. . . . **Dr. Charoen Savetamal,** Belle Plaine, told how his family came to the United States from Thailand at recent meeting of Belle Plaine Rotary Club. Dr. Savetamal and his wife, **Dr. Ngampen Savetamal,** are associated with the Four County Medical Center. . . . **Dr. H. E. Stroy,** Osceola, was honored at an open house November 10 for his 50 years of medical service to this community. In addition to his medical practice, Dr. Stroy served on the Osceola School Board for 15 years and on the State Board of Health for 20 years—the longest tenure of any Iowa physician.

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**Dr. L. C. Hickerson,** longtime Brooklyn physician, was honored November 3 at an open house in recognition of medical service to the community. Dr. Hickerson has practiced in Brooklyn since 1940. At the reception Dr. and Mrs. Hickerson were presented a check for over $5,000 to be used

for a trip to Hawaii. . . . **Dr. K. Jean Marshall** is closing her practice in Washington December 27. She will join a new group practice in Phoenix, Arizona, in January. . . . **Dr. D. E. Tyler,** Marshalltown, discussed electrocardiograms at recent meeting of the community's Licensed Practical Nurses in Marshalltown. . . . **Dr. Scott Helmers,** Sibley, has been named vice president of Lakes Area Health Planning Council. . . . **Dr. Robert M. Kretzschmar,** associate professor, Department of Obstetrics and Gynecology, U. of I. College of Medicine, is new 6th District chairman, American College of Obstetricians and Gynecologists. . . . **Dr. Selig Korson,** superintendent, Independence Mental Health Institute, addressed members of Iowa Dietetic Association at October meeting in Marshalltown. . . . **Dr. Joseph Spearing,** Harlan, has been named a director of the Health Planning Council of the Midlands. . . . **Dr. Wayne Severson,** vice president of medical affairs for Blue Cross and Blue Shield, was guest speaker at November meeting of Johnson County Medical Society.

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**Dr. Robert Schafermeyer** began the solo practice of medicine in Eldora in November. Dr. Schafermeyer recently completed a 15-month duo internship-residency in varied medical and surgical rotations at Mayo Clinic in Rochester, Minnesota. . . . **Dr. Glenn C. Blome,** retired Ottumwa surgeon, was guest speaker at November meeting of Wapello County Medical Society. Dr. Blome's topic: "A Century of Medicine in Wapello County." Material for the program was drawn from old county medical society minute books, "Medical History of Wapello County" by the late Dr. Clyde A. Henry, of Farson, and Dr. Blome's 40 years of experience as a practicing physician in Ottumwa.

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**Dr. W. E. Owen,** St. Ansgar, and **Dr. James C. Carr,** New Hampton, have been appointed instructors in family medicine at the Mayo Medical School in Rochester, Minnesota. . . . **Dr. Reginald R. Cooper,** head of the U. of I. Department of Orthopedic Surgery, is new member of the state board of physical therapy examiners. . . . **Dr. John S. Gillam,** assistant professor, U. of I. College of Medicine, has been named instructor of obstetrics and gynecology at Broadlawns-Polk County Hospital in Des Moines. Dr. Gillam formerly practiced in Fargo, North Dakota. . . . **Dr. D. M. Tan Creti,** Denison, was guest speaker at recent meeting of Crawford County Memorial Hospital Auxiliary. Dr. Tan Creti discussed types of therapy. . . . **Drs. Charles Jons,** Ames, **John F. Murphy,** Boone, **Robert Jones,** Des Moines, and **Ralph L. Wicks,** Boone, were guest speakers at organizational meeting of Physician's Assistant Society in Madrid. Topics discussed: Dr. Jons—ear problems; Dr. Murphy—importance of records; Dr. Jones—head injuries and Dr. Wicks, IMS president—role of PA's in delivery of Iowa health care.

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**Dr. Marten McKenney** is new consulting radiologist at Manning General Hospital. Dr. McKenney is also providing radiology service to Stewart Memorial Hospital in Lake City and Loring Memorial Hospital in Sac City. . . . **Dr. Roger Muken** has joined the McFarland Clinic in Ames. A Boone native, Dr. Muken received the M.D. degree at U. of I. College of Medicine and completed his otolaryngology residency at University of Minnesota. . . . **Dr. John J. Shurts** retired November 15 after 30 years of practice in Eldora. Dr. and Mrs. Shurts will retire in Brownsville, Texas. . . . **Dr. William J. Morrissey** has left Des Moines to join the North Phoenix Medical Center in Phoenix, Arizona, where he will practice internal medicine. . . . **Dr. James O. Stallings,** Des Moines, attended recent meeting of the American Society of Plastic and Reconstructive Surgeons in Houston, Texas.

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## DEATHS

**Dr. C. E. Thomas,** 91, former Keystone physician, died November 13 at Americana Nursing Home in Waterloo. Dr. Thomas received the M.D. degree in 1913 at U. of I. College of Medicine. He began his medical practice in Keystone in 1916 and retired in 1962. He was a Life Member of Iowa Medical Society.

**Dr. John E. Kimball,** 88, a practicing physician in West Liberty since his graduation from U. of I. College of Medicine in 1908, died unexpectedly December 2 at his home. Dr. Kimball was a Life Member of Iowa Medical Society.

**Dr. Thomas L. Vineyard,** 88, an Ottumwa physician since 1949, died December 4 at Ottumwa Hospital. Dr. Vineyard received the M.D. degree at Atlanta School of Medicine, Atlanta, Georgia. Following 58 years in the practice of medicine, Dr. Vineyard retired in 1966. He was a Life Member of Iowa Medical Society.

# LIST YOUR WANTS

**GRADUATE PROGRAMS IN MATERNAL AND CHILD HEALTH**—1. Graduate Program for Physicians in Mental Retardation and Related Disabilities; 2. Maternal and Child Health; 3. Community Pediatrics; 4. Community Obstetrics. School term begins: September, 1975, January, 1976, Fees: Regular school tuition. For further information contract Dr. Ruben Meyer, Director, School of Public Health, University of Michigan, Ann Arbor, Michigan 48104.

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**WANTED—GENERAL PRACTITIONER**—to join another doctor in friendly, rural community of New Sharon, Iowa. Population 1200, 11 miles from Oskaloosa, Iowa. Serve 3-4 other small communities and large rural area. Write or call Richard E. H. Phelps, M.D., 109 North Main, New Sharon, Iowa 50207. 515/637-2621 or 515/637-2246.

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**LOCUM TENENS WANTED**—Internist or Family Practice physician in Des Moines Clinic. Address your inquiry to No. 1502, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

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**GENERAL PRACTITIONER**—Geriatric Interest—Psychiatric Hospital. Liberal fringe benefits. Near recreation areas and State Capital. Beginning salary $27,287 to $31,806 depending on qualifications. Internship, U. S. citizen and licensure required. Equal opportunity employer. Contact Louis Jensen, M.D., VA Hospital, Knoxville, Iowa 50138.

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**GENERAL PRACTITIONER NEEDED**: Friendly rural community. Moville, Iowa, population 1,200, 14 miles east of Sioux City, Iowa. Unlimited opportunity for a family physician. Phone 712/873-3158 or 712/873-3455.

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**MEDICAL UNDERWRITER NEEDED**—interesting work evaluating risks as well as involvement in the insurance aspect of providing medical care. Secure position with good future and good corporate hours and benefits. Call or write Fred Dinkler, M.D., Medical Director, The Bankers Life, 711 High, Des Moines, Iowa 50307. 515/284-5445.

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**WANTED—FAMILY PHYSICIAN** to associate with four-man clinic. Accredited hospital, full surgical and radiological coverage. Contact Paul Vander Kooi, M.D., Orange City, Iowa 51041. Call 712/737-4938 office or 712/737-4104 home.

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**DIRECTOR—ALCOHOLIC TREATMENT CENTER**—located in a 676-bed acute care general hospital. This 40-bed unit has functioned successfully for 1½ yrs. based upon a team approach to treatment of the alcoholic. Full time is preferred but some part time private practice is negotiable. Excellent salary with attractive benefits. Interested persons please send curriculum vitae to Donald J. Courtright, Ass't. Admin., Iowa Methodist Hospital, 1200 Pleasant, Des Moines, Iowa 50308.

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**FOR SALE**—100 M.A. GE X-ray; Bucky, fluoro., and all accessories. Write or call Robert Dolan, M.D., 101 College Drive, Decorah, Iowa 52101. 319/382-3133.

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**WANTED—MEDICAL DIRECTOR**—Family practitioner to serve in health clinic. No Sunday or holiday work. Basic 40-hour week. Salary, $36,000 a year. If interested, please contact Clinic Manager, Evelyn Davis Health Clinic, 1154 5th Avenue, Des Moines, Iowa 50314. Phone 515/283-2571.

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**WANTED—FAMILY PRACTITIONER** to join 8-man multi-specialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time. Contact Richard A. Callis, Administrator, McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712/464-3194.

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**WANTED—GP/FAMILY PRACTITIONER** in Council Bluffs, Iowa. Salary $50,000. After 2 years, if agreed by both parties, full partnership. Gross in 1973, $150,000. Desire sabbatical for 2 years. Write or call J. V. G. Angel, M.D., 1705 McPherson, Council Bluffs, Iowa 51501. Call 712/328-2231, office or 712/323-1443, residence.

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**BUSY THREE-MAN FAMILY PRACTICE PARTNERSHIP** in Marshalltown, Iowa (pop. 30,000) needs replacement for one partner leaving for a residency. Salary first year and then full partnership. Hospital facilities across the street. 200-bed well equipped hospital. Contact E. L. Jacobs, M.D., Marshalltown, Iowa 50158 for further details. Phone 515/752-3449.

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**NAVY CAREERS NOW MORE ATTRACTIVE**—Many physicians in military service may qualify for special pay of up to $13,500 per year due to a new variable incentive pay bill. Eligibility is dependent on review of particular circumstances. Increments plus base pay and fringe benefits can bring annual income into line with civilian doctors. Today there's more reason than ever to look into the challenge of a Navy Medical Corps career. For complete information, please call toll free—515/284-4183, or contact Medical Programs, Navy Recruiting District, Room 693, Federal Building, Des Moines, Iowa 50309.

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**LOCUM TENENS NEEDED**—July 3 to August 7, 1975, in rural family practice. Salary $3,500. Housing and car available. Swimming pool and tennis court within one block. Golf course one mile outside of town. Contact W. H. Verduyn, M.D., 514 Main Street, Reinbeck, Iowa 50668. Phone 319/345-6461.

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American Medical Association ..... 6B

Burroughs Wellcome Co. ..... 10A, 31

Flint Laboratories ..... 30A, B

Geigy Pharmaceuticals ..... 34A, B

Lilly, Eli & Company ..... 1

McNeil Laboratories ..... 27

Medical Protective Company ..... 13

Pharmaceuticals Manufacturers Association ..... 10B, 11

Prouty Company ..... 34

Roche Laboratories ..... 2-3, 14-15, 20B, C, 39-40

Roerig & Co. ..... 6A

Searle, G. D. & Co. ..... 20D, 21

Smith, Kline and French ..... 20A

World Wide Health Care Air Force ..... 32

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• Involvement Is Vital—Page 48
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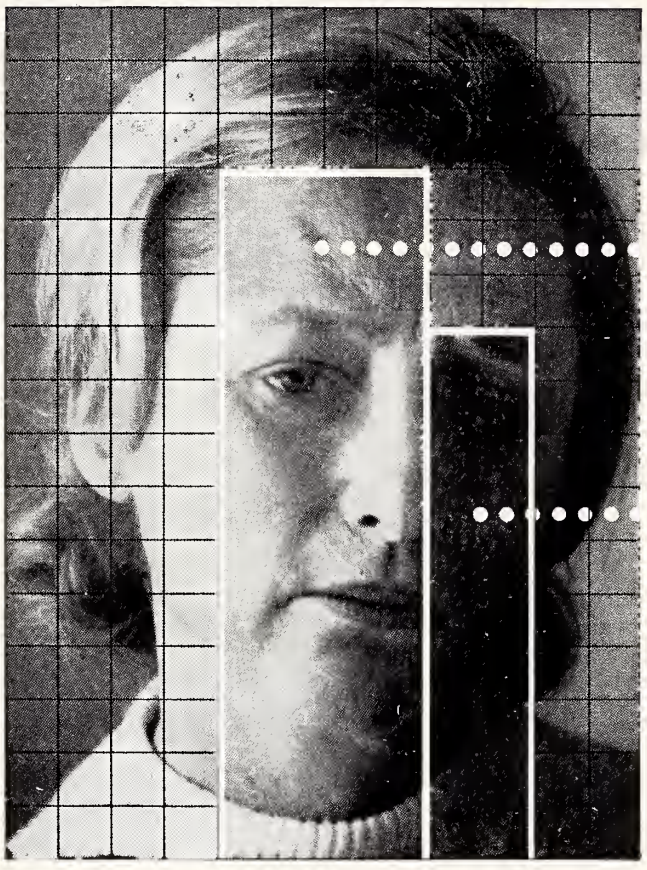
FEBRUARY 1975

# Both often



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# respond to one

According to her major mptoms, she is a psychoneu- tic patient with severe nxiety. But according to the escription she gives of her elings, part of the problem ay sound like depression. his is because her problem, though primarily one of ex- ssive anxiety, is often accom- anied by depressive symptom- ology. Valium (diazepam) n provide relief for both—as e excessive anxiety is re- ved, the depressive symp- ms associated with it are also ten relieved.

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in psychoneurotic anxiety states with associated depressive symptoms

rveillance because of their predisposi- n to habituation and dependence. In egnancy, lactation or women of child- earing age, weigh potential benefit gainst possible hazard.

**recautions:** If combined with other psy- notropics or anticonvulsants, consider arefully pharmacology of agents em- loyed; drugs such as phenothiazines, arcotics, barbiturates, MAO inhibitors nd other antidepressants may potentiate s action. Usual precautions indicated in atients severely depressed, or with latent epression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# President's Page

In visiting with a non-physician friend recently, the subject of PSRO came up. I was impressed with his knowledge of the subject since his business is real estate and insurance.

My friend contends the self-policing concept offers the medical profession an opportunity to maintain (or regain, as he put it) public trust. He had read the article, "How Good Is Your Doctor," in NEWSWEEK magazine (12/23/74). This stimulated his interest and prompted further study.

The basically-balanced article summarized PSRO, supported the peer review philosophy and stressed the need for flexibility. It cited, as factors compounding our extremely complex medical care picture, rising costs, heavy specialization, professional liability, and the ever increasing sophistication of medical science.

Most physicians believe in peer review. They tend to rebel at the governmental dictates now surrounding it. But if we establish our own fair and equitable peer review procedures, we may be able to make it work in spite of (not because of) bureaucratic mandates.

The NEWSWEEK article said: "Since only a physician can truly judge how well or badly his colleagues perform, it is the medical profession itself that must bear the blame for the incompetent or miscreant doctor. Yet there is ample evidence that the profession has done poorly at policing its own ranks."

This is our challenge. A good system of peer review has been emerging in Iowa over the past several years. We need to continue to expand and refine this system in the interests of the profession and the public.

Sincerely,

Ralph L. Wicks

*Ralph L. Wicks, President*

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# IOWA Medical Miscellany

**REGIONAL CONFABS . . .** Five late-winter informational briefings for Society members have been authorized by the IMS Board of Trustees. Scheduled for March, the afternoon sessions will include status reports on such key topics as PSRO, medical liability, hospital/medical staff relations, legislation and AMA programming. More details as to dates, locations and program appear on page 49.

**IFMC/PSRO . . .** A final application for conditional PSRO status has been prepared by the Iowa Foundation for Medical Care and is in the process of submission to HEW.

**IMMUNIZATION SURVEY . . .** School immunization survey of Iowa kindergarten/first grade pupils (81.4% response) showed the following 1974 immunization levels (1973 results in parentheses): polio (3 plus doses)—79.8 (69.8); DPT (3 plus doses)—86.2 (84.3); measles—80.2 (76.2); rubella—70.1 (71.0); mumps—57.9.

**LEGISLATIVE DINNER . . .** Iowa's lawmakers will be hosted at a February 6 dinner by the member organizations of the Iowa Health Council. The IMS is among the 9 groups which comprise the IHC.

**LEADERSHIP CONFERENCE . . .** An Iowa Health Council Leadership Conference will occur from noon to 4 p.m., February 6, at the Des Moines Club. Topics include PSRO, federal health planning legislation, continuing education and state legislative activity. Conference is for officers and leaders of the IHC member organizations.

**FOR SPECIALTY GROUPS . . .** An IMS briefing session was presented January 30 for presidents and officers of the various medical specialty organizations in Iowa. Current medical issues were discussed.

**PROFESSIONAL LIABILITY . . .** Nine legislative items aimed at alleviating the professional liability problem were approved January 30 by the IMS Executive Council. Included were proposals concerned with statute of limitation, informed consent, contingency fees, etc. Also approved was a feasibility study of an IMS group professional liability program. This will be undertaken in partnership with Rollins Burdick Hunter Company of St. Louis, Missouri.

**CONTINUING EDUCATION . . .** Representatives of the IMS Board of Trustees and Committee on Medical Education and Hospitals met in January with members of the Board of Medical Examiners to discuss matters pertaining to continuing medical education.

**MORE ON CME . . .** Rutledge Howard, M.D., associate director, AMA Department of Medical Education, conferred in January with the IMS Committee on Medical Education and Hospitals over the process by which the Society may achieve status as a CME accrediting unit in Iowa.

**CONSIDER UPDATE . . .** Need for revision of the long-standing code of cooperation between physicians and pharmacists is being considered by the IMS Committee on Interprofessional Activities. Suggested revisions or additions will be reviewed with officials of the Iowa Pharmaceutical Association.

**HANDBOOK PREPARATION . . .** The 1975 Handbook for the House of Delegates is in the preparatory stage with reports being received from the Society's nearly 50 standing and special committees.

*(Please turn to page 60)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 2
FEBRUARY 1975

## TABLE OF CONTENTS

The Overburdened Physician: A Point of View
B. Frank Vogel, M.D. . . . . 51

Cervical Cancer Among Iowans
Guru S. Bale, Ph.D. . . . . 53

Prospective Analysis of Retrograde Ureteral Catheterization
C. E. Hawtrey, M.D., E. K. Larson, M.D., and J. D. Schmidt, M.D. . . . . 57

### EDITORIALS

What'll You Have? . . . . . 61
Death . . . . . 61
Analogies . . . . . 62
Crooked Ears . . . . . 62

### SPECIAL DEPARTMENTS

President's Page . . . . . 44
Iowa Medical Miscellany . . . . . 45
The Question Box . . . . . 47
In the Public Interest . . . . . 48
State Department of Health . . . . . 50
Educationally Speaking . . . . . 66
Medical Assistants . . . . . 68
About Iowa Physicians . . . . . 71
Deaths . . . . . 75

### MISCELLANEOUS

Tackle Key Issues at March Meetings . . . 49
IMS Nominating in March . . . . . 59
Sales Tax Exemption for Certain Devices . . 60
New AMA CME . . . . . 66
Plan 1975 MECO . . . . . 67
April Pediatrics Conference . . . . . 67
Continuing Education Courses and Conferences . . . . . 67

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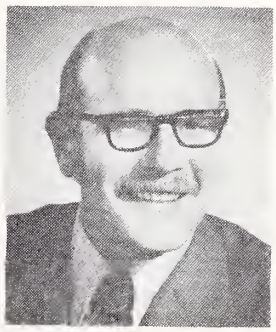
# The Question Box



by DONALD W. DUNN

*Mr. Dunn is President of the Iowa Hospital Association, which has its headquarters in Des Moines.*

**The Iowa hospital system is probably the state's major service program. Can you offer any statistical highlights to underscore this?**

One hundred forty-eight hospitals have been created in 113 communities to help meet the personal health needs of Iowans. The efforts of many individuals were required, most often with physician leadership, to create these social institutions. The methods of holding in trust the tremendous needed resources are varied and interesting. They include city, county or state governmental sponsorship, or the uniquely American mechanism of voluntary, non-profit corporate ownership, many of which are church related.

Statistical information which provides an insight into the significance of the Iowa hospital service enterprise is the people power involved: Iowa hospitals (a) employ 35,210 persons, (b) are governed by 1,500 trustees, (c) have the care they provide directed by 2,400 physicians who are members of medical staffs, and (d) are aided by 48,000 auxilians who provide thousands of hours of volunteer help. This amounts to 87,110 persons and means that one of every 30 Iowans is involved actively in the direction and provision of hospital care and hospital based services. The total assets ($571,614,000) and annual operating costs ($412,512,000) provide another dimension of the service offered to Iowans by hospitals. Perhaps the best statistical measures relate to the number of people served annually. In 1973, 529,519 persons were hospitalized and received 5,363,000 days of inpatient care. In addition, there were 1,952,000 emergency and other out-patient visits that year.

If all of these figures tend to boggle the mind, it may be helpful to recall that more than one of six Iowans seek care each year in the social institutions created by our communities. They come, at the direction of their physician, needing help at the time of greatest physical and psychological distress. Relief for their distress is afforded, in the greatest of Judaic-Christian traditions, because of resources marshaled by communities and embodied in social institutions called hospitals.

**Are Iowa hospitals up to meeting the demands of this last quarter century?**

The hospital has changed radically from what it was in 1950. Its resemblance in the year 2000 to the hospital of 1975 will be equally difficult to discern. As medical science advances, the hospital must change; as social and cultural values change, the hospital must adapt; as financial and organizational structures are modified, the hospital must adjust. In 25 years we may have LHP's, HMO's or HCC's across the state; we may have yet unmentioned organizational and financing mechanisms. The health problems being treated and the procedures being followed may be entirely different. The term "hospital" may become obsolete. But, in any event, people will be caring for people. It will require manpower, organization and facilities. Guided by people, many of whom are among the most dedicated and gifted, the hospital in Iowa, by whatever name, will meet the demands of the time—1985, 2000, or 2025.

**In what areas are the most pressing hospital needs—economics, physical facilities, or what?**

Pressing needs for physical facilities and personnel are ever changing, yet ever the same. The solutions found through the creation of modern facilities are never permanent. Similarly, the problems of scarcity and maldistribution of manpower will involve change in health disciplines, solutions will be transitory, and the most press-

*(Please turn to page 64)*

# Rx FOR GOOD GOVERNMENT: PARTICIPATION

THERE ARE THOSE who believe strongly in the federalization of all endeavor. Obviously, too, there are others who support local autonomy with equal fervor. When these basic points of view come together there is frequently sharp and candid debate. This is good.

In fact, it's great that freedom and opportunity exist for honest pursuit of any philosophy or position. Taking advantage of this opportunity is our hang-up. Many citizens simply forfeit the privilege of expressing reasoned opinion on a governmental issue. And most simply avoid any involvement in political activity.

Events of the recent past have not enhanced the desire for participation in the political and governmental process. But standing on the sidelines, criticizing the players, won't do the trick, or recoup the setbacks which may have been sustained. Getting into action is the important thing.

The promotion of good government is important whether you are a painter, a plumber, a poet or a physician. It is essential to recognize the rules of the game have their genesis at the ballot box. Tax provisions, welfare programs, health care measures, etc., are molded by elected officials. Ultimately, some make their way into the law books.

There are individuals who and organizations that have accepted and maintained long-term commitments to fostering good government. Among these organizations, for example, is the Iowa Medical Political Action Committte (IMPAC). This body of Iowa physicians is committed to the proposition that electing good men and women to national and state offices is the best way to assure the conscientious enactment of legislation which is in the public interest.

So it is appropriate, as the Iowa General Assembly and the U. S. Congress move into 1975 sessions, to acknowledge the important role of organizations such as IMPAC in our vital political process. The need for participation by Iowa physicians in IMPAC is great, just as is participation by other individuals in similar organizations which are based on high ethical principles. Any organization which operates from this premise and seeks to elect qualified citizens deserves recognition for its involved advocacy of the governmental enterprise.

It is quite appropriate as well to acknowledge those who serve now in the Iowa General Assembly and the U. S. Congress. These lawmakers have a real assignment. The scope of their considerations is virtually spectrum-wide. They must understand and evaluate the gross weight restrictions on trucks one minute and matters involving the commitment of the mentally ill the next.

The governmental process hits every aspect of our American lifestyle. The delivery of health care is part of the bureaucratic swirl. It is mind-boggling for the average citizen—let alone the average physician—to maintain anything bordering on a comprehensive understanding of the increasing governmental involvement in the provision of medical care.

To afford some impression of the magnitude of it all, bear in mind that 26,222 bills and resolutions were introduced in the 93rd U. S. Congress. Of these, more than 2,700 were of interest to medicine. Over 40 of these have been signed into law.

Out of the 93rd Congress has come a new comprehensive health planning law. The law gives state and local health agencies, under federal supervision, new powers over hospital and health facility construction and services.

It replaces the present comprehensive health planning program and the regional medical programs with a complicated new system of federal standards and regulations covering state and local health planning agencies that would have more authority over medical facility building and operations.

The law provides for the establishment of local and state agencies to develop comprehensive health plans under national guidelines prepared by the Secretary of HEW. It requires all states to enact certificate of need legislation and expands existing review authority to include au-

thority to review existing facilities and services as well as proposed facilities. These are only several of the aspects of the new law.

To those who subscribe to a belief in local or state autonomy this law presents ominous implications. The medical profession opposed its enactment vigorously. As a matter of fact, the American Medical Association even now has declared its intention of going to court to have the law declared unconstitutional as an unwarranted assumption of state authority by the federal government.

But this discussion is not essentially for the purpose of discussing the consequences of this law. Reference to the legislation is made to illustrate the magnitude of the issues which bear on one of society's important sectors—health care delivery.

Iowa physicians—as do all citizens—have a responsibility and obligation to transmit forthright and positive suggestions on legislative measures to their elected state representatives. And the members of the General Assembly must have listening and receptive ears. They must weigh the facts carefully and vote thoughtfully.

The governmental process is not without faults. Its checks and balances give it an unwieldy nature. But, as they say, it can only be as good as the people participating in it and actively supporting it.

# Tackle Key Issues at March Meetings

Five significant issues confronting Iowa physicians will be up for examination during March at five regional briefings being offered by the Iowa Medical Society. Status reports on current activity in each area will be presented. The afternoon sessions will commence with lunch and conclude at approximately 4 p.m. They will be open to all Iowa physicians and interested spouses.

The meeting schedule is as follows:

Wednesday, March 12—Atlantic
Thursday, March 13—Spencer
Wednesday, March 19—Amana
Thursday, March 20—Waterloo
Wednesday, March 26—Des Moines

Physicians are welcome to attend the meeting of their choice. The selection may be made for convenience on the basis either of location or date. The presentation of material will be similar at each session. Society representatives with special expertise in the several areas will present current information and respond to questions.

The program topics are as follows:

- THE MEDICAL STAFF AND THE HOSPITAL
  *A review of current developments influencing physician-hospital relations.*
- PSRO & IFMC
  *A status report on the efforts of the Iowa Foundation for Medical Care to achieve PSRO designation.*
- PROFESSIONAL LIABILITY
  *An analysis of the professional liability picture in Iowa with emphasis on current IMS activity.*
- THE AMERICAN MEDICAL ASSOCIATION
  *A report on recent AMA actions relative to dues and membership.*
- IMS LEGISLATIVE PROGRAM
  *A summarization of the climate in the Iowa General Assembly with a review of the health care measures under consideration.*

A full program with a reservation form will be sent to the membership within the next several weeks. IMS members are urged to reserve a convenient date and so notify Society headquarters on the reservation card. Further information on the series is available on request.

# State Department of Health

## EXPANDING PUBLIC HEALTH NURSING SERVICES IN IOWA

THELMA LUTHER, R.N.
Director, Nursing Section

Public health nursing services in Iowa have increased greatly in recent years. In 1966, only 43 Iowa counties had public health nursing service. The majority of these counties had one public nurse. Ninety counties are now covered by public health nursing services. Sixty-seven of the 90 counties receive joint funding from the Iowa State Department of Health; five counties are independently financing their nursing service; nine additional counties are covered by services from combination agencies, hospital-based home care programs, etc.; and nine counties receive special project funds from the Iowa State Department of Health. Twelve counties employ hourly nurses for home health services in addition to the county public health nurses, and five employ practical nurses. Sixty-one counties employ two or more nurses; 31 employ three or more. The only counties with no public health nursing service are Adair, Bremer, Butler, Clarke, Fremont, Greene, Guthrie, Page and Sac counties.

Public health nursing agencies, whether operating with official or voluntary funds, give a similar service. They serve all financial brackets and all age groups. They charge a fee for their care of the sick services, according to the patient's ability to pay, and service is given free if the patient cannot pay. Some services are paid for by public and private insurance programs. The services are varied and include those to expectant parents, new mothers and babies, preschool and school children and crippled children. Public health nurses help plan and execute preventive care programs in such areas as immunization, well child conferences, and diabetes detection. They care for the sick in their homes and often eliminate the need for hospitalization. Their presence frequently permits a patient to return home earlier from the hospital. They give health care counseling to persons of all ages. They hold classes for such groups as expectant parents. They meet with community groups such as PTA and Extension Service to plan health programs.

The following is a comparison of the number of services provided by nurses employed in official agencies in the years 1966 and 1973:

| | *1966 (Av. of 58 Nurses Employed)* | *July 1, 1973-June 30, 1974 (Av. of 126 Nurses Employed)* |
|---|---|---|
| TOTAL SERVICES GIVEN | 53,800 | 112,966 |
| Antepartal | 464 | 1,030 |
| Postpartal | 488 | 1,685 |
| Tuberculosis | 4,799 | 1,508 |
| Other communicable diseases | 1,606 | 1,229 |
| Chronic illness | 17,768 | 74,811 |
| General health supervision | 21,669 | 25,955 |
| Mentally ill and retarded | 3,109 | 4,734 |

Some miscellaneous services are not included in the above tables.

In 1966 Medicare and Medicaid programs started and included home health care. As a result, public health nursing services were altered considerably to include more care of the sick at home. This time consuming service required more nurses. To be eligible to receive Medicare and Medicaid reimbursement an agency must be certified by the Social Security Administration. Considerable work is required to obtain certification. It is necessary to organize an advisory group, write policies, establish an evaluation method, improve records and establish an additional home service such as home health aides, physical therapy, etc.

Currently, 59 home health agencies in Iowa are

*(Please turn to page 64)*

SCIENTIFIC ARTICLES

# The Overburdened Physician: A Point of View

B. FRANK VOGEL, M.D.
Cherokee

*All things to all people. Is the physician so cast? Should he be primary counselor to the terminally-ill patient? The author believes physicians should know and observe their limitations.*

MORE AND MORE aspects of life are being referred to the physician for partial or complete help. Often these problems are of an extraordinarily difficult nature. Should they all be directed to the physician?

The physician is of above average intelligence and presumably has a fairly stable personality. He has been trained to do a special type of work. But his mastery is not all encompassing, into matters environmental, social, economic, ecological, emotional, sexual, vocational, etc. Yet he is asked to assume increasing responsibilities, to decide upon matters and give considered opinions on subjects outside his realm.

Why is this happening? One is helped to understand why by looking back 100 or more years, people turned to their physician because he was, as the word "doctor" means, a learned person. He might have been the only person, aside from the minister or lawyer, or perhaps the schoolmaster, with broad competence. It was comforting to believe the physician knew everything and could help.

There are interesting and speculative explanations of this when you trace the physician's role back to the priest-physician of the Greeks, to the witch doctor, to the Shaman, and to the Wiseman-Herbalist of the tribe. The psychoanalysts have suggested that, unconsciously, there is a parental transference to the physician and, therefore, omnipotence and omniscience are ascribed to him. These are partial explanations. By the nature of his work, the physician is physically close to people. He helps them with disordered body functioning, and he alleviates pain.

## ALL PURPOSE COUNSEL

Is there some extraordinary and unbounded generalization that derives from this? If the physician can help with physical pain he can help with problems that have to do with all other kinds of pain; with unhappiness, with disappointment at the way the world is going, or with discontent and resentment over socio-economic problems.

It is flattering to be considered knowledgeable, capable and compassionate. In many cases, this flattery becomes an accepted conviction, and causes the physician to undertake tasks, responsibilities and emotional involvements for which he has no special talent.

The author is a psychiatrist and is director of Clinical Services at the Mental Health Institute in Cherokee, Iowa.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF FEBRUARY, 1975.

Life has become exceedingly complex and with this has come a useful division of labor. We have many people with new areas of specialization to whom we can look for worthwhile counsel and help. The physician should not feel he is the only resource people have. It may well be he is the first person to whom his patients may turn, but just as he would refer a complicated medical problem, so should he refer problems when his competency is no greater than that of any lay person. He should avoid permitting himself to be pedestalized and should not offer pronouncements on matters removed from his area of expertise.

### THE DYING PATIENT

There are great pressures upon all physicians to concern themselves with the dying. Without question, the physician has his duties and should continue them throughout the patient's life. However, do these duties of the physician include helping his dying patient accept the prospect of death? Is every physician suited by training or by temperament to manage this formidable task? This latter question requires a "no" answer. Physicians are people. It is wrong to accept the image of the physician held by many: that they have a totally even temperament, that they are unparalleled in dedication, greatly compassionate, infinitely adaptable and can help in every possible eventuality. This is not true.

Even when the physician is able to help and comfort a dying patient, is he necessarily the one for the task? If it is to be done, it should be done well. It cannot be done without a considerable degree of emotional involvement.

Can the physician afford the emotional involvement? He has other patients, living patients, suffering patients, who need his skills and who need his emotional support. To give emotional support to a dying patient is a draining experience. For every dying patient, there are three devastating fears. The first is that of pain, the second is that of being abandoned, and the last, is the terror of that final moment when reality will disappear.

To be able to help a dying patient with these three problems requires so much from a physician that it is psychologically unwise for every physician to be so involved. Should this be the physician's task, even for the most dedicated and the most compassionate? Are there not others—worthy people, compassionate people, dedicated people, who can and will make it their concern to deal with the dying man and his fears?

### THE CLERGY

Time was when the minister or priest played the major role after the physician announced that medical skills could do no more. We have read, and perhaps have heard from friends or relatives, about the "comfort of religion" being given to the terminally ill patient. It is far wiser to look to a minister, a priest, an old friend or a dear relative for these last comforts, rather than to the physician. Such people have been and are able to give a great deal more than the physician. Spending an extra 10 minutes with a terminally ill patient is not giving him any special comfort. The only kind of comfort that is of value is a deep emotional giving.

The emotional care of the dying is one of many new responsibilities that has been placed upon the physician's shoulders. The demands and needs of people—in time of pain and unhappiness —will be ever with us. They turn to someone, most often the physician. The physician should recognize and accept his limitation cognitively, sociologically and, most certainly, emotionally. He must recognize that in areas where he knows he is not temperamentally suited, where he knows his training has been nil or inadequate, he must refuse to be thrust or implored into assuming overwhelming responsibilities that are not within his domain.

## VIEWS OF SCIENTIFIC EDITOR

M. E. Alberts, M.D., Scientific Editor of the JOURNAL OF THE IOWA MEDICAL SOCIETY, offers his editorial reaction to Dr. Vogel's discussion of the role of the physician in relating to the terminal patient. Dr. Alberts' editorial on this subject appears on Page 61 of this issue of the JOURNAL. If you have an opinion you would like to express, write "Letters to the Editor," JOURNAL OF THE IOWA MEDICAL SOCIETY, 1001 Grand Avenue, West Des Moines, Iowa 50265.

# Cervical Cancer Among Iowans

GURU S. BALE, Ph.D.
New York City

*Projections on the prevalence of cervical cancer are made from 11,496 pap tests in 1972 and 1973. Deaths from cervical cancer are reported to have decreased from 135 in 1955 to 76 in 1968.*

CANCER OF THE CERVIX can be identified in an early, curable stage by a pap test. Once identified, the disease can be treated effectively to prevent many deaths.[1] Pap test sensitivity (ability of the test to detect a person having cancer of the cervix) is 86%, and the specificity (ability to detect a person having no cancer of the cervix) is 99.1%.[2] In spite of the availability of this test, many women do not seek or receive a pap test.

There are over 70 million women 20 years and over in the United States. Each year, more than 6,500 die of cancer of the cervix. In Iowa, of the 921,000 women 20 years and over, about 80 die annually of cancer of the cervix.

This paper provides information on incidence and mortality rates from cancer of the cervix.

## METHODS AND MATERIALS

The family planning centers provide pap tests to women using their services. Between September 1972 and January 1973, a total of 11,496 persons received pap tests in Iowa family planning centers. The results of these pap tests are used in arriving at the incidence rates.

Deaths registered during 1968-71 with the Iowa State Department of Health were searched and deaths due to cancer of the cervix were selected for the study. The information on the mortality cards pertaining to age, county of residence, month of death and marital status were included in the analysis.

Population data required to compute age-specific rates were estimated from 1970 census figures for Iowa. The mid-year population estimates of Iowa for 1968-71 were proportionately distributed to each age group, according to these census figures.

## RESULTS

### *Morbidity*

From September 1972 through January 1973, the family planning centers provided pap tests to 11,496 women in the child bearing age (15-44 years). The results of the pap test are shown in Table 1. Malignant cells were observed in 2 persons. This gives an incidence rate of 1.73 per 10,000 women tested. Severe dysplasia was observed in 6 persons (5.21 per 10,000). The pap test classified 88% of the women tested as negative and another 6.86% as negative, no dysplasia, with active metaplasia.

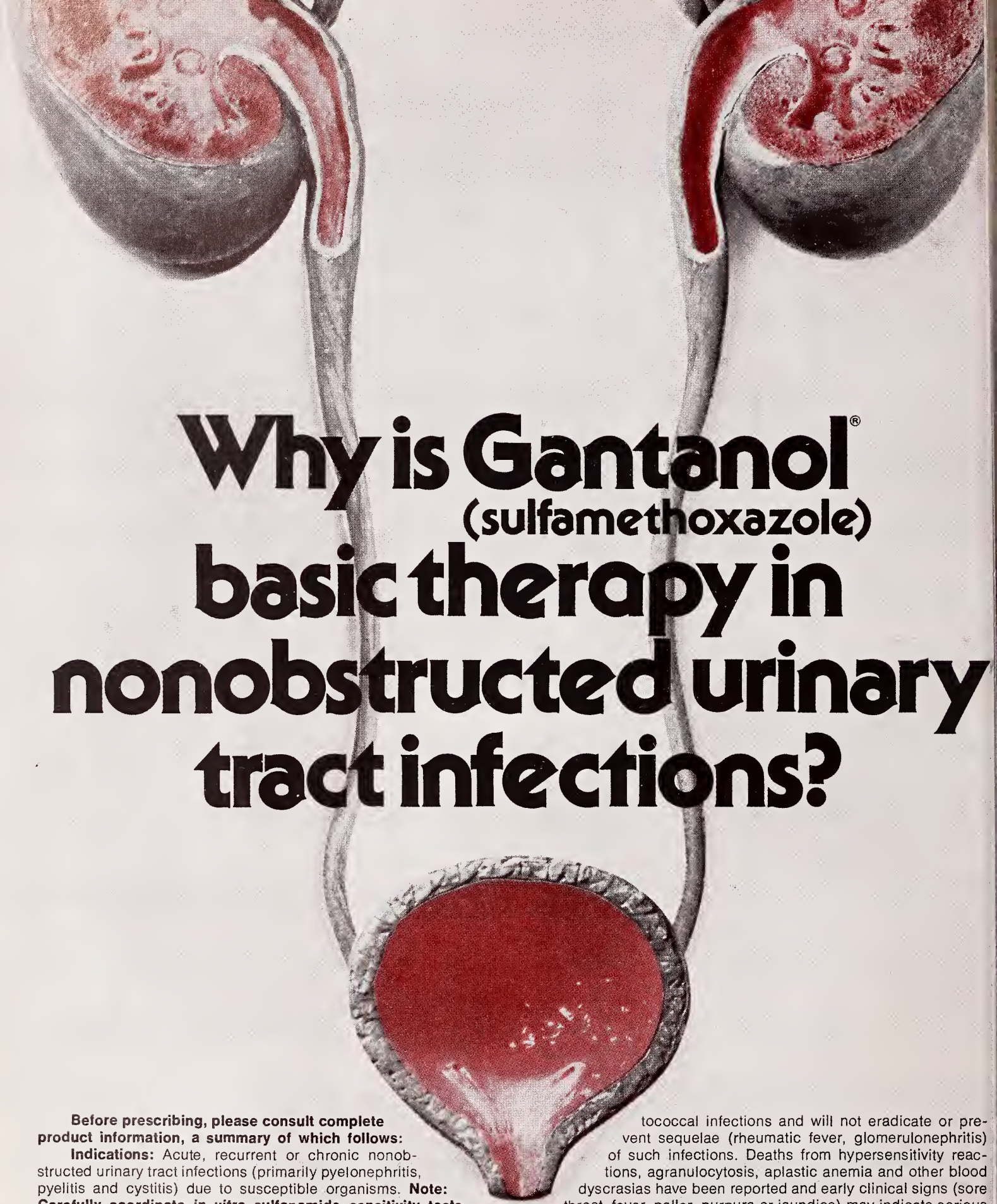
TABLE 1

PAP TEST CLASSIFICATION OF 11,496 WOMEN SCREENED IN 15 FAMILY PLANNING CENTERS—SEPTEMBER 1972-JANUARY 1973

| | *Classification* | *Number* | *Percent* |
|---|---|---|---|
| | Total | 11,496 | 100.0 |
| I | Negative, no dysplasia cells observed | 10,117 | 88.0 |
| II | Negative, no dysplasia, active metaplasia observed | 789 | 6.9 |
| II+ | Dysplasia minimal | 724 | 3.7 |
| IIIA | Dysplasia mild or moderate | 105 | 0.9 |
| III | Dysplasia moderate | 43 | 0.4 |
| III+ | Dysplasia moderate to severe | 10 | 0.09 |
| IV | Dysplasia severe | 6 | 0.05 |
| V | Malignant cells observed | 2 | 0.02 |

Using the observed incidence rate of 1.73 per 10,000 among those tested, it is estimated that each year, there are 80 to 90 new cases of cancer of the cervix among women in the child bearing

Dr. Bale was associated with the Records and Statistics Division of the Iowa State Department of Health when these statistics were compiled. He is now employed by the Metropolitan Life Insurance Company in New York City.



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**Indications:** Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

**Contraindications:** Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

**Warnings:** Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

**Adverse Reactions:** *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, pur-

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### Tablets/Suspension
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pura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

**Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age** (except adjunctively with pyrimethamine in congenital toxoplasmosis).

*Usual adult dosage:* 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

*Usual child's dosage:* 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

**Supplied:** Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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TABLE 2

CANCER OF CERVIX DEATHS, RATE PER 100,000 POPULATION BY AGE GROUPS—IOWA 1968-71

| | Number of Deaths | | | | Rate/100,000 Population | | | |
|---|---|---|---|---|---|---|---|---|
| Age Group | 1971 | 1970 | 1969 | 1968 | 1971 | 1970 | 1969 | 1968 |
| 20-30 | 1 | 1 | 1 | 3 | 0.05 | 0.05 | 0.05 | 1.56 |
| 30-40 | 7 | 6 | 4 | 4 | 4.69 | 4.06 | 2.71 | 2.72 |
| 40-50 | 16 | 18 | 17 | 11 | 9.93 | 11.29 | 10.68 | 6.93 |
| 50-60 | 17 | 13 | 22 | 19 | 8.52 | 8.61 | 14.60 | 12.64 |
| 60-70 | 17 | 16 | 22 | 17 | 13.36 | 12.71 | 17.51 | 13.56 |
| 70-80 | 11 | 24 | 17 | 14 | 11.39 | 25.11 | 17.83 | 14.72 |
| 80 & above | 13 | 6 | 10 | 7 | 26.29 | 12.27 | 20.49 | 14.37 |
| Total | 82 | 86 | 94 | 75 | 5.59 | 5.92 | 6.49 | 5.19 |

age. Using the incidence data of 1969-71,[4] the number of new cases of cervical cancer is estimated at 180 for women 45 years and older. Hence, the estimated incidence of cervical cancer among Iowa women is 18.6 per 100,000 female population. According to the third national cancer survey in 1969-71, the average age adjusted incidence rate for cancer of the cervix in Iowa is 16.8 per 100,000 population.

*Mortality*

During 1968-71, there were 327 deaths due to cancer of the cervix. The average age at death was about 60 years and did not differ significantly from year to year.

The death rate for cancer of the cervix in 1971 was 5.59 per 100,000 female population. The 1971 rate is slightly lower compared to the previous two years. The age-specific death rate was lowest among women in the 20-30 age group (0.5 per 100,000 women), and higher among women in the older age groups (Table 2). Ninety per cent of the total cervical cancer deaths were among women 45 years and over.

The distribution of cervical cancer deaths by county of residence is reasonably even. Polk County leads in number of deaths and is the only county with more than 10 deaths for each of the years, 1968 to 1971. In the four-year span, only Linn, Black Hawk, Scott and Woodbury counties recorded more than 14 deaths.

## DISCUSSION

Mortality from cervical cancer deaths has declined in recent years. Cervical cancer deaths decreased from 135 in 1955, to 119 in 1960, to 104 in 1965, and to a low of 76 in 1968. The 3-year moving average during 1954-71 also indicates a declining trend in cervical cancer deaths. This decline may be attributed to the availability of the pap test for early diagnosis and also to increased cervical cancer screening activities. In spite of the decline in cervical cancer deaths, the American Cancer Society estimates that 433,000 women in Iowa, aged 20 years and over, have not had pap test. This estimate is based on the national figures. In the United States, it is estimated that 47% of the women aged 20 years and over, out of 70 million, have not had a pap test.[3]

According to Greenwald, *et al*,[1] at least 12% of the deaths can be prevented if pap tests are done routinely among hospitalized female patients. This conclusion was reached because 12% of the women who died of cervical cancer had been hospitalized during the five years prior to the death but had not had a pap test. It is not known how many hospitals in Iowa do pap tests on all women at the time of admission to the hospital.

The number of cervical cancer deaths is expected to decrease further as more women are screened for this cancer. Furthermore, the increased screening activities in the State by the family planning centers and other agencies should have a favorable impact on the incidence of morbidity and mortality from cervical cancer.

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# Prospective Analysis Of Retrograde Ureteral Catheterization

C. E. HAWTREY, M.D., E. K. LARSON, M.D., and J. D. SCHMIDT, M.D.
Iowa City

*Ureteral catheterization can be safely carried out on those with chronic renal insufficiency. No patient in reported series developed significant renal impairment from instrumentation.*

The concern of the urologist for ureteral catheterization side effects dates from the technique's inception in the early part of this century. Braasch[1] beautifully describes the developments and painstaking research of retrograde pyelography. Throughout this period and to the present, numerous investigators were concerned about antisepsis associated with retrograde pyelography. The original colloidal silver solutions maintained their own antimicrobial properties while the early bromine and iodine sodium salts assured no antibacterial effectiveness. Kidd[2, 3] added mercury oxycyanide to his sodium iodide contrast media in an effort to maintain antisepsis. Cunningham, Graves and Davis[4] added dilute mercuric iodide to their sodium iodide contrast media for germicidal properties.

With the development and subsequent improvement of intravenous pyelography, the indications for retrograde pyelography have gradually decreased. Relative antiseptic technique and possible pyelotubular or pyelolymphatic retrograde inflammatory reaction into the kidney decreased the enthusiasm for this diagnostic procedure. The urologists' concern and the procedure's relative merits have not been adequately conveyed to our referring colleagues, the family practitioners and internists. Castellino and Marshall's[5] experimental studies attempted demonstration of these retrograde mechanisms. Earlier, Tennant,[6] Strousman[7] and Wossidlo[8] observed retrograde spread of colloidal silver solutions into the parenchyma under excessive pressure of contrast material.

Concern for the indications for retrograde pyelography has been expressed by many authors. McCrae[9] suggests that uremia and renal insufficiency are contraindications to retrograde pyelography. Pollock[10] cautions that bacteria may enter the kidney via pyelovenous, pyelolymphatic or pyelointerstitial backflow. The author, however, did not state the incidence of this problem in retrograde instrumentation of the urinary tract. Castellino and Marshall,[5] in an artificial study with complete occlusion of the ureter demonstrated transport of radioactive sodium diatrizoate, $I^{131}$, across the renal and ureteropelvic mucosa. Their experiment was carried out under conditions not representing actual retrograde catheterization in that the ureter was doubly ligated, forming a closed system. The authors felt the pressure relationships of their experiment, however, simulated human retrograde pyelography. The possibility of transmission of organisms by similar mechanisms must be considered.

## MATERIAL AND METHODS

A prospective study, relating renal function to infection via retrograde pyelography, has been undertaken in our institution involving a series of 50 consecutive patients over a six-month period. The surgical procedure carried out by resident and staff urologists conformed to strict aseptic technique in which disposable or gas-sterilized catheters were used. All patients received post-instrumentation, urinary antiseptics or antibiotics. Postoperatively all individuals were interviewed to elicit symptomatology and followup evaluation

The authors are associated with the Department of Urology, College of Medicine, University of Iowa, Iowa City, Iowa.

TABLE I

SUMMARY OF POST-INSTRUMENTATION DEATHS

| *Patient* | *Age* | *Admitting Diagnosis* | *Pre-Study Creatine* | *Study* | *Post-Retrograde Therapy* | *Mechanism of Death* | *Autopsy* |
|---|---|---|---|---|---|---|---|
| AT ..... | 61 | Multiple myeloma. Renal failure | 23 mg% | Bilateral blocking ureterograms: Normal | Peritoneal dialysis | Cardiovascular | Renal involvement with multiple myeloma |
| AR ..... | 67 | Bowel obstruction | 12 mg% | Right retrograde: Normal | Peritoneal dialysis | Cardiovascular | Bronchopneumonia. Pulmonary edema. Acute tubular necrosis—kidney |
| BT ..... | 59 | ASHD with CHF. Sepsis CVA | 3.9 mg% | Bilateral retrograde: Normal | IV fluids. Antibiotics | Sepsis— Blood culture: Pseudomonas aeruginosa Urine: Candida | NONE |

by urinalysis, blood urea nitrogen, creatinine, creatinine clearance, and bladder urine culture estimated the functional and bacteriologic integrity of the urinary tract. The ages of our patients ranged from 17 to 76 years. Forty (40) per cent of the patients (including seven dialysis patients) had renal insufficiency characterized by a serum creatinine greater than 3 mg%. Twenty patients (40%) had no cellular elements on preinstrumentation urinalysis, while 67% of the patients had insignificant cultures prior to instrumentation. Twenty-five of the retrograde instrumentations were carried out bilaterally by ureterogram or pyelographic techniques, with approximately equal distribution of the unilateral procedures between the left and the right sides. In most cases the period of instrumentation was 5 to 10 minutes; however, some individuals required indwelling ureteral catheters up to 23 days. The size of ureteral catheter used varied; the most frequently used were #5 French whistle-tipped catheters and #8 cone-tipped catheters. Thirty-two retrograde pyelographic diagnoses were described as "unobstructive" or "normal." Post-instrumentation antimicrobial therapy included Ampicillin, 500 mg, every 6 hours; Keflex, 500 mg, every 6 hours; Chloramphenicol, 500 mg, every 6 hours; Tetracycline, 250 mg, 4 times daily; Gantanol, one gm, twice daily, and Macrodantin, 50 mg, 4 times a day.

## RESULTS

Eleven patients had a temperature elevation in the post-retrograde period, usually rising 1° C and clearing within one day. One patient complained of back pain following instrumentation without oliguria and his symptoms cleared within 24 hours. Urinalysis findings remained unchanged in 53% after instrumentation. In 29% of patients the urinalysis improved following retrograde studies, as a result of the treatment instituted following the study. Only 18% of patients demonstrated an increase in the number of red or white cells seen in the postoperative urinalysis. Only seven (14%) patients had significant positive urine cultures following retrograde catheterization. All culture material was removed from the bladder and some of these patients required indwelling urethral catheters post-instrumentation.

There was, however, an apparent predilection for positive urine cultures in the group with chronic renal insufficiency. Five of 20 patients (25%) with chronic renal insufficiency had significant positive urine cultures post-retrograde pyelography. Only 2 of 30 patients (7%) in the non-renal insufficiency group developed positive cultures, and all cultures cleared within the patients' hospitalization. No positive urine culture was associated with signs or symptoms of acute urinary tract sepsis except when sepsis was present prior to retrograde catheterization. Three patients died 6, 7 and 22 days following retrograde catheterization, but in no instance could the cause of death be directly assigned to the instrumentation of the urinary tract. Table I summarizes the data of the patients who died.

Post-retrograde renal function studies showed no significant changes in blood urea nitrogen,

TABLE II

PATIENT AVERAGE

| | Age | Bun | Creatinine | Creat. Clear. | Olig. |
|---|---|---|---|---|---|
| Normal Function, negative culture | 47 | 18 | 1.0 | 72 | |
| Chronic Renal Insufficiency, negative culture | 41 | 96 | 11.3 | 13 | 4 of 14 pts. |
| Chronic Renal Insufficiency, positive culture | 59 | 107 | 12.5 | 1.4 | 3 of 5 pts. |

creatinine or creatinine clearance. Neither retrograde ureterograms nor retrograde pyelograms produced significant increases in positive urine cultures following such instrumentation. The investigating urologist preferred blocking ureterograms for evaluation of chronic renal insufficiency patients, although this was not significant.

Interesting comparisons could be made in three categories of patients as follows: a) normal renal function with negative urine culture; b) chronic renal insufficiency with insignificant urine culture, and c) chronic renal insufficiency with positive urine culture.

Table II implies that the more severe the renal insufficiency, the more likely the patient will develop a positive urine culture. These individuals demonstrate no systemic manifestations of infection unless infection was present pre-instrumentation.

Ten patients demonstrated significant urine culture prior to instrumentation and only 3 cultures remained positive following treatment. Two of the preceding patients developed yeast infections following treatment for their bacterial infections, and one patient maintained the pre-treatment organisms. Four additional patients developed significant urine cultures following instrumentation which were controlled by appropriate antimicrobial therapy.

We concluded from the study that uremic patients require careful monitoring of the bacteriologic status of the urinary tract and instituting appropriate antimicrobial therapy where indicated. Urine cultures should be obtained after therapy either before hospital discharge or upon return office visit.

## SUMMARY

Ureteral catheterization can be safely carried out in individuals with chronic renal insufficiency. This instrumentation is associated with a slightly higher incidence of positive urine cultures, which is not associated with systemic manifestations of urinary tract infection. This instrumental examination is not associated with significant morbidity, although approximately 20 per cent of patients developed transient elevation of temperature of 1° C. No patient developed significant renal impairment resulting from instrumentation. Since the advent of modern antimicrobial therapy, retrograde pyelography continues a safe procedure for upper urinary tract evaluation.

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# IMS NOMINATING IN MARCH

The 1975 Nominating Committee of the Iowa Medical Society will meet at Society Headquarters on Sunday, March 23. District caucuses are being held in advance for the purpose of (1) selecting representatives to the Nominating Committee, and (2) discussing possible candidates for IMS offices in 1975-76. Society members are welcome to attend their particular district caucus.

# SALES TAX EXEMPTION FOR CERTAIN DEVICES

Legislation enacted by the 65th Iowa General Assembly exempted from sales tax the sale of prosthetic, orthotic and orthopedic devices for human use. The exemption applies to all sales of these devices made on or after July 1, 1974.

A prosthetic device does *not* require a prescription to qualify for the exemption from sales tax. The purchase of an orthotic or orthopedic device, which is a piece of special equipment used to straighten a deformed or distorted part of the human body or to preserve and restore the functions of the human skeletal system, its articulations and associated structures, requires a prescription to qualify for the exemption from sales tax. Persons purchasing orthotic and orthopedic devices without a prescription will be subject to the 3% sales tax.

Iowa physicians may place the prescription in written form for the patient to present to the seller at the time of purchase, or if the patient knows where he is going to purchase the device, the physician may telephone the prescription to the seller.

## IOWA MEDICAL MISCELLANY

*(Continued from page 45)*

**NEEDY PHYSICIANS . . .** Society members are reminded of the relief fund for needy physicians operated by the Scanlon Medical Foundation/IMS. This program was created through provisions in the will of Dr. Henry Albert. Assistance under the program should be directed to the Foundation through a county medical society.

**'75 SPONSOR . . .** IMS will again serve as co-sponsor of the Northwest Iowa Summer School on Chemical Substances and Other Addictions. 1975 school will be June 8-13 at the Iowa Lakes Community College. County medical societies will again be invited to sponsor local youth attendance at the week-long school.

**HEADS IRAG . . .** Paul Seebohm, M.D., Executive Associate Dean, U. of I. College of Medicine, has succeeded John Tyrrell, M.D., Manchester, as chairman of the Iowa Regional Advisory Group (IRAG) of the Iowa Regional Medical Program (IRMP).

***IMPORTANT INFORMATION:*** *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

*Indications:* Lomotil is effective as adjunctive therapy in the management of diarrhea.

*Contraindications:* In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

*Warnings:* Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

*Usage in pregnancy:* Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

*Precautions:* Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

*Adverse reactions:* Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

*Dosage and administration:* ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

*Overdosage:* Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

*Dosage forms: Tablets,* 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## WHAT'LL YOU HAVE?

This is your JOURNAL. We are interested in your desires. We are concerned about what constitutes a good state medical journal. We can assume satisfaction when we do not hear complaints.

I had the pleasure of attending a recent workshop on medical journal composition sponsored by Sandoz Pharmaceuticals and held at the University of Missouri. Editors of several state medical journals met with journalism professors to discuss ways and means of providing better publications. One major question which arose again and again pertained to makeup and style of a medical journal. Various journals were analyzed and compared to others. Basically, it appears our JOURNAL stands up quite well with other state medical journals, but we are not satisfied with that. We desire to be better, but we want some input from our readers. What'll you have? What areas of our publication do you like? What seems undesirable?

Journalists of course concern themselves with style and makeup, as well as content. Our financial resources limit some aspects of this. More and more we have improved the style of our JOURNAL. The section headings are striking and effective. We would like more dramatic photography.

Some comments have come to me from time to time, and I invite more of these. Let us hear from our readers. What do you want in your JOURNAL? We will listen to you, and strive to do the best we can with the resources available.—M.E.A.

## DEATH

*This editorial comments on the article by Dr. Vogel which begins on page 51.*

Death is a mystery. For some it creates great fear; for others a hoped-for peace. No one can relate the experience of death, so we must postulate regarding this mystery. Are physicians to hold themselves above this phenomenon, and serve only the living? Elsewhere in this issue, Vogel writes of death and the "overburdened physician." He wonders at the "great pressure upon all physicians to concern themselves with the dying." He denies that the physician should help his dying patient accept the prospect of death; suggesting that to give emotional support to a dying patient is a draining experience. Vogel points out that the patient has three devastating fears—pain, abandonment, and the final moment of reality. Those fears may be very real and valid, but should the physician, to whom the ill patient turned, suddenly turn his back at another hour of need? That action presents an attitude of abandonment, thus intensifying the fear. Such does not seem consistent with compassion and thoughtfulness. It does not seem consistent to our calling to expect a "death consultant" to enter the scene.

Patients often have a premonition of death. Some inner feeling registers within the patient's mind that the cessation of reality is near. Sometimes this is not attended by outward fear, but more with the urgent "final preparations." We use the term "getting our house in order." That might mean the execution of a proper last will and testament, or it may mean a renewed religious faith. Three years ago my father died. He was a religious man in his own way, though he did not attend church regularly. However, he in-

sisted that his children did. His final stay in the hospital was less than one day. During his last day he asked that his pastor be summoned to administer Holy Communion. This was done, and death occurred before the pastor returned to his study at the church. My father was not alone, though members of the family were not present. Peace was his, and certainly fear was overshadowed by that peace. But, what if his physician had entered the room at that final moment, or had been the one asked to summon the pastor? Should he have turned away because he was "overburdened"? I think not.

As I interpret Doctor Vogel's provocative essay, I sense a feeling that he is caught in a dilemma for which he cannot be held in ridicule —a dilemma between a fear of death itself and an attitude that a physician always must be a perfectionist. I sincerely hope the implication is not that the dying person needs an expert present during those final moments. I am sure that simple compassion, plain naturalness, and true sincerity would be acceptable.—M.E.A.

## ANALOGIES

Do analogies interest you? Recently we received a communication from Doctor George Braunlich of Davenport, Iowa, in which he draws analogies between personal and professional experience. Dr. Braunlich was graduated from medical college in 1915 and has practiced in Davenport since 1918. He has served the Iowa Medical Society in many ways (AMA Delegate, 1953-55), and was honored as a Life Member in 1965.

In the analogy drawn, Dr. Braunlich likens past experiences to water over the dam. Years of professional experience have provided Dr. Braunlich an extended view of the many changes in medical practice. Living along the Mississippi River has afforded him the opportunities to observe the flow of much water—over the dam as well as in uncontrolled floods.

Experiences of physicians in diet management of diabetes mellitus, with low salt intake to control hypertension and in the prevention of renal stones by diet restriction, represent experiences and knowledge of the past—now water over the dam. Yet, control can be attained by using the methods at hand. Experience of prevention can be equated to experiences of the results of treatment. If management of a disease maintains control, perhaps similar management of the disease before it appears can prevent it in known susceptible persons. Another example is the use of proper diets in children when their family history shows a strong incidence of obesity and hypercholesterolemia. The past may be water over the dam, but what of the future? Will there be waste of knowledge, or profit from experience? —M.E.A.

## CROOKED EARS

Another indicator of minimal brain dysfunction has been reported. Many of the affected children have asymmetrical ears, according to a report by Kent E. Durfee, M.D.* From the Menninger Clinic, Dr. Durfee enlarges on this aspect of the physical status of these unfortunate children. Anomalies of the ears have been correlated previously with malformations of the genito-urinary and cardiovascular systems. The external ears, including the canals, are formed from the first and second branchial arches and migrate cephalad from below the mouth to their final position. A major portion of this basic formation is during the first 12 weeks of gestation, at the same time the central nervous system is forming.

Neurological assessment of minimal brain dysfunction at best is unclear and non-specific. The electroencephalogram and the roentgenograms of the skull yield meager results. Psychologic evaluation does not provide conclusive data. Now, it is suggested to note the asymmetry of the placement of the external auditory canals. The subject is viewed from the full-face position and from the top of his head while the examiner holds his index fingers in the patient's external auditory canals.

Durfee presents data which he feels does substantiate this relatively reliable screening technique for the possible existence of a congenital central nervous system dysplasia. It will be interesting to see how often this finding is present in our patients with minimal brain dysfunction. —M.E.A.

* Durfee, K. E., Crooked ears and the bad boy syndrome: asymmetry as indicator of minimal brain dysfunction. Bull. of Menninger Clinic, 38:305-316, 1974.

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**Indications:** For management of fever associated with common childhood infections.

**Contraindications:** Sensitivity to acetaminophen or the suppository base.

**Warnings:** Not for use in children under three years of age. Should not be administered repeatedly to patients with pulmonary, cardiac, renal, or hepatic disease.

**Precautions:** Prolonged administration may result in such withdrawal symptoms as restlessness and excitement when the drug is discontinued.

**Adverse Reactions:** No significant adverse reactions have been reported with NEOPAP (acetaminophen) SUPPRETTES. However, adverse reactions associated with administration (usually chronic) of this drug have included the following:

**Blood:** Cyanosis, methemoglobinemia, sulfhemoglobinemia, and hemolytic anemia; neutropenia, leukopenia, and pancytopenia.

**Allergic:** Skin eruptions, urticaria, fever.

**Other:** Hypoglycemia, CNS stimulation, jaundice.

**Dosage and Administration:** Children 3 to 6 years of age: One 2 gr suppository rectally 3 or 4 times daily; not to exceed 8 grains per day.

Children 6 to 12 years of age: One 5 gr suppository rectally 3 or 4 times daily; not to exceed 20 grains per day.

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## QUESTION BOX

*(Continued from page 47)*

ing needs will vary from rural to urban settings. Currently and in recent years, statewide, the most pressing challenge has been in the area of finance. Under federal compulsory regulation, Iowa hospitals were placed in serious jeopardy for continued fiscal integrity. If adequate and appropriate means to finance hospital services acceptable to the people being served are not found, the problems of physical facilities and personnel will be exacerbated, and the quality of health care will suffer measurably.

**The medical staff and the administration make institutional health care go. How would you characterize relations generally among these two important entities?**

"Creative tension" is a phrase which often, not undesirably, characterizes relations between the hospital medical staff and hospital management and governance. Complete mutual understanding and total cooperation are key to an ideal state of affairs, sometimes accomplished and always to be desired. Distrust and its predictable offspring, conflict, do occur in isolated instances, but are not in the public interest and should be avoided. Management more and more understands the imperative of inclusion of the medical staff in planning and key administrative decisions. The intrusion of government into all levels of local health affairs has brought home to all parts of hospital leadership the necessity of acting together. Physicians are recognizing that, as medical staff members, they are an integral part of the affairs of an organization which needs their loyalty and expertise if the hospital is to survive with effectiveness in changing times. Increased cooperation at local, state and national levels makes me an optimistic participant in the provision of quality health services to the people of Iowa.

## STATE DEPARTMENT OF HEALTH

*(Continued from page 50)*

certified to provide home care service under the Health Insurance Benefits for the Aged Program. These agencies provide service to 70% of Iowa's population. Several more agencies are preparing for certification.

Another new and rapidly expanding government program involves health screening for children. In July 1972, a new dimension was added to the Title XIX program in Iowa. This program requires that all youth served by aid to dependent children (ADC) program must have access to health screening facilities and must be referred for the correction of any defects found. There are 70,000 children under 21 years of age in Iowa who are eligible for these services. In some counties physicians do the screening. In other counties, physicians have requested public health nurses to set up screening centers. To do the screening, public health nurses must first, have additional training which is being provided on an ongoing basis by the State Department of Health. Screening by public health nurses is being done in centers in 28 counties.

With continually expanding public health nursing programs, more public health nurses will be required. Where care of the sick services are supplied, there should be approximately one public health nurse per 2,500 population. To meet this criteria, there will need to be aproximately five times as many public health nurses as there are now. This additional number will be difficult for counties to finance immediately but the need is there. This area should be considered as communities plan for future health services.

### GONORRHEA FINDINGS

The Iowa State Department of Health laboratory program for detection of gonorrhea has been in operation for two years. Since this bacteriology program (culture test) was started, 121,765 persons have been tested and 3,425 (2.8%) were found to be infected.

A recent analysis of a group of 37,902 persons tested revealed 38.5% of those infected were under 20 years of age and 93% were under 30.

The Department of Health is available to assist in presenting workshops to prepare persons to teach certain aspects of venereal disease. Please contact the Venereal Disease Section of the SDH.

# The post-T & A patient:

## another type for TYLENOL® acetaminophen products

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

**References: 1.** Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

**Precautions and Adverse Reactions:** If a rare sensitivity reaction occurs, the drug should be stopped. Acetaminophen has rarely been found to produce any side effects.

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# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## WAS VIRCHOW RIGHT?

In his doctoral dissertation Rudolph Virchow, the great founding giant of anatomic pathology, attempted to defend the thesis that "only the liberal-minded can gain insight into the nature of medicine." I wonder what you understand by "liberal-minded" and if you agree that it is necessary for insight into medicine.

Do you suppose liberal-minded means about the same as "stretchable?" To have true insight or understanding must mean more than memorizing facts. It must relate to the ability to apply data and skills to the solving of problems. From the time one first formally begins the study of medicine upon entering medical school through all one's days as a practitioner, one must learn new facts, apprehend new relationships, and gain increasing skill in applying them to the resolution of psychosocial-pathophysiologic disturbances. A stretchable mind must by definition be expandable to "hold more" but also be able to modify its contour to accommodate the unusual shapes of ideas that may not "pack" in the usual way. The physician who continues to study through reading, listening, interacting with colleagues, and observing carefully his own patients cannot avoid that kind of changing, growing, expanding, liberalizing. He will deliberately cultivate a "garbage-can mind." But remember the implied warning of Dr. Oliver Wendell Holmes: "Sometimes a person's mind is stretched by a new idea and never goes back to its old dimensions."

Or does "liberal-minded" refer to a friendly receptivity toward the "liberal arts"? Osler wrote that "professional work of any sort tends to narrow the mind, to limit the point of view . . . (Whether) from concentration (or) apathy, (the professional) is apt to neglect those 'outside studies' that widen the sympathies and help a man to get the best there is out of life." I would hope that the physicians in Iowa will take advantage of, and receive delight from a multifaceted continuing education that will enrich life far beyond what will usually be construed as continuing *medical* education. How can it be done? Perhaps more than anything else by keeping curiosity alive and refusing to let either the usual workaday pressures or the numbing weight of affluence compress us into a stale intellectual contentedness.

And finally, could insight into medicine possibly be dependent upon being "liberal-minded" in the political meaning of liberal? You decide.

Dr. Caplan is Associate Dean, Continuing Medical Education at The U. of I. College of Medicine.

## NEW AMA CME

The American Medical Association's new program of regional continuing education for physicians is being launched this year with meetings in Florida, Arizona, Minnesota and Virginia. The weekend courses are being conducted by the AMA's Council on Scientific Assembly.

Selection of two of eight courses is possible in the weekend program which provides the highest category of continuing education credit. The midwestern session will be in Minneapolis July 26-27. Full details are available from the AMA.

## PLAN 1975 MECO

Iowa hospital support is now being sought for the 1975 MECO (Medical Education and Community Orientation) Program. This summer job-education program for medical students has progressed significantly since it was begun approximately five years ago.

Goal of the MECO program is four-fold: 1) To enable students to evaluate career goals and plan their medical education in relation to community health care needs; 2) To introduce students to the organization and operation of health care institutions and their relation to total community care; 3) To enable the student to understand the basic concept of patient-oriented health care; and 4) To introduce the pre-clinical student to clinical aspects of medicine as a reinforcement and motivational force.

Last summer MECO placed 81 students (77 Iowa and 4 out of state) in 52 hospitals. Consensus among the participating hospitals has been favorable. Ninety-three per cent of the hospital administrators indicated their belief the MECO progam would help increase the retention of Iowa trained physicians.

Similarly, over 80% of the student participants in 1974 MECO said they would return for another summer and would recommend it to other students. Over 90% appreciated the exposure to clinical medicine during their heavy involvement with basic sciences. Over 60% of the students expressed interest in establishing a rural community practice.

MECO is an activity of the Student American Medical Association. It is endorsed by the Iowa Medical Society, the Iowa Academy of Family Physicians, the Iowa Hospital Association and the U. of I. College of Medicine. Much program planning and coordination is accomplished by the first-year medical students.

## APRIL PEDIATRICS CONFERENCE

The 19th annual Pediatric Conference at the Raymond Blank Memorial Hospital for Children in Des Moines will occur April 10 and 11. Sponsors of the Conference are the Raymond Blank Hospital Association, the Blank Hospital Guild, the Division of Maternal and Child Health of the Iowa State Department of Health, and the Iowa Chapter of the American Academy of Pediatrics.

Theme of the two-day Conference will be Infectious Diseases.

Guest faculty will include Martin Myers, M.D., assistant professor of pediatrics, University of Iowa; Pierce Gardner, M.D., director, Infectious Diseases Training Program, University of Chicago; W. Paul Glezen, M.D., associate professor of pediatrics, University of North Carolina; and David L. Ingram, M.D., assistant director, UNC Pediatric Teaching Program, Raleigh, N. C.

For further information, please contact L. A. Wintermeyer, M.D., director, Pediatric Education, Raymond Blank Memorial Hospital for Children, 1200 Pleasant Street, Des Moines, Iowa 50308.

# Continuing Education Courses & Conferences

*Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.*

| | |
|---|---|
| Feb. 5 | Ophthalmology Clinical Conference |
| Feb. 11 | Sociological Perspectives of Cancer |
| Feb. 11-14 | Refresher Course for the Family Physician |
| Mar. 5 | Diet Therapy U.S.A. |
| Mar. 5 | Ophthalmology Clinical Conference |
| Mar. 11 | Viral Etiology of Cancer |
| Mar. 24-27 | Cardiology Today |
| April 2 | Ophthalmology Clinical Conference |
| April 7-11 | Intensive Course in Pediatric Nutrition for Nutritionists and Dietitians |
| April 30-May 1 | Annual Meeting—IMS HOUSE OF DELEGATES |
| April 30-May 1-3 | Course and Workshop on Echo-Ophthalmography |

# Medical Assistants

by TENORA MEYER, CMA

## AMA/CPT

This fall's Blue Shield area workshops for Iowa medical assistants considered the new coding system which involves the American Medical Association Current Procedural Terminology (AMA/CPT). Although not required at present, medical assistants were urged to begin using the new 5-digit AMA/CPT code, along with entry of the procedure.

The American Hospital Association has required hospitals to code diseases and procedures for years. Card files or automated listings are maintained for statistical and research purposes. Originally, the Standard Nomenclature for Diseases and Operations was widely used. Gradually, the swing has been toward the simpler International Classification of Diseases, Adapted (ICDA).

The AMA's Current Procedure Terminology is now in its third edition. This edition has been adopted by Blue Shield and is being implemented gradually. Eventually procedures will be referred to only by the digit method—as, for example, appendectomy, which is 44950.

It has been suggested that each physician's office develop a list of frequently used procedures for ready reference. Blue Shield has made available a mini-listing of approximately 225 procedures. This listing is believed to contain those medical services most frequently provided by physicians. For the coding of less commonly performed services, it is necessary to refer to the full AMA/CPT.

A sample billing form from Texas which utilizes the CPT coding was contained in the workshop material. It listed the common procedures, including office, hospital and home visits obstetrical procedures, ECG, chest x-ray and common surgical procedures with the CPT code inserted and space provided for the fee. This approach helps assure accurate coding and reduces clerical handling time.

For unlisted procedures or services, code numbers have "–99" as the last two digits for the five major sections and "–9" for sub-sections.

A modifier is used to record a service or procedure that has been modified but has not changed in its identification or definition. It may indicate reduced or increased service, part of a service, adjunctive service such as assistant in surgery, or indicate that a service or procedure was provided more than once. Eighteen letters are used as modifiers—one example is the letter "Q" after the usual procedure number to indicate the assistant surgeon's fee.

Unusual surgical procedures, which include indefinite pre- and postoperative services, where the usual "package" concept cannot be applied, require an asterisk be added to the code.

Copies of the AMA/CPT have been distributed to most Iowa physicians.

## S-O-A-P POMR

Progress notes in clinical or hospital practice may be more definitive with the problem oriented medical record system now in wide use. Nurses report physicians strongly approve of this system for nurses' notes where the system has been tried. It summarizes the current problem of the patient in an easy-to-read manner.

S, of course, refers to subjective;
O—Objective
A—Assessment
P—Plan

The progress notes indicate the problem number under the S-O-A-P headings.

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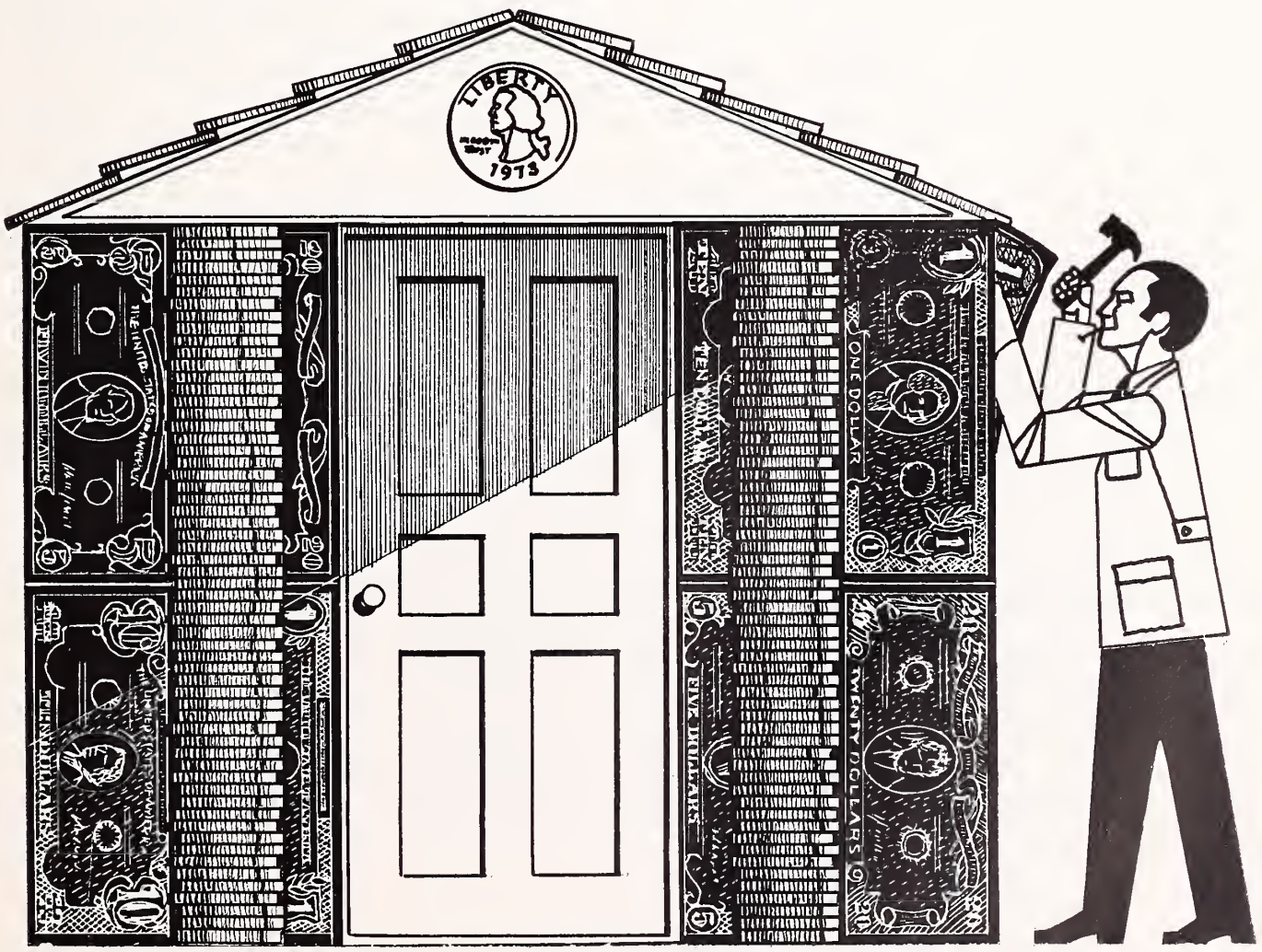

# Morbidity Report for December, 1974

| Disease | December 1974 | 1974 to Date | 1973 to Date | Most December Cases Reported From These Counties |
|---|---|---|---|---|
| Amebiasis | 3 | 34 | 79 | Boone |
| Amebiasis & Giardiasis | 1 | 6 | | Boone |
| Ascariasis | 1 | 11 | 5 | Boone |
| Brucellosis | 12 | 29 | 10 | Dubuque, Tama |
| Chickenpox | 1082 | 8748 | 12467 | Audubon, Black Hawk, Dubuque, Polk |
| Conjunctivitis | 263 | 1198 | 1049 | Decatur, Johnson, Polk, Story |
| Encephalitis, viral | 1 | 18 | | Black Hawk |
| Encephalitis, type unspec. | 1 | 15 | | Howard |
| Erythema infectiosum | 25 | 593 | 344 | Guthrie, Kossuth, Marshall, O'Brien |
| Gastrointestinal viral inf. | 5434 | 20120 | 7653 | Bremer, Dallas, Howard, Linn, Story |
| Giardiasis | 2 | 44 | 22 | Pottawattamie |
| Guillian-Barré syndrome | 2 | 14 | | Poweshiek, Scott |
| Hepatitis, A (Infectious) | 12 | 270 | 220 | Polk, Pottawattamie |
| Hepatitis, B (Serum) | 7 | 91 | 50 | Polk |
| Hepatitis, type unspecified | 9 | 56 | | Pottawattamie, Scott |
| Histoplasmosis | 7 | 26 | 11 | Johnson |
| Impetigo | 110 | 710 | 476 | Carroll, Linn, Winnebago, Winneshiek |
| Infectious Mononucleosis | 156 | 1204 | 786 | Black Hawk, Johnson, Linn, Polk, Story |
| Influenza-like illness | 6794 | 106977 | 14690 | Bremer, Clayton, Linn, Madison, Story |
| Influenza, lab confirmed | 3 | 120 | | Johnson |
| Meningitis Aseptic | 2 | 58 | | Adams, Scott |
| *H. influenza* | 2 | 7 | 7 | Pottawattamie, Scott |
| Type unspecified | 4 | 46 | 35 | Clayton, Pottawattamie, Scott |
| Mumps | 97 | 1985 | 4095 | Linn, Muscatine, Pottawattamie |
| Pediculosis | 65 | 742 | 21 | Black Hawk, Cerro Gordo, Muscatine |
| Pinworms | 3 | 65 | 13 | Black Hawk, Polk, Scott |
| Pneumonia | 92 | 1015 | 1195 | Dubuque, Marshall, Scott |
| Psittacosis | 1 | 1 | | Story |
| Rabies in Animals | 12 | 130 | 214 | Scattered |
| Rheumatic fever | 5 | 59 | 17 | Bremer, Butler, Warren |
| Ringworm, body | 48 | 280 | 142 | Dubuque, Linn, Woodbury |
| Ringworm, scalp | 4 | 19 | 5 | Buchanan, Jackson, Muscatine |
| Salmonellosis | 18 | 191 | 227 | Scattered |
| Scabies | 56 | 206 | 236 | Cerro Gordo, Des Moines, Johnson |
| Shigellosis | 15 | 307 | 275 | Dubuque, Johnson, Polk |
| Streptococcal infections | 1205 | 10562 | 7435 | Dubuque, Jackson, Johnson, Marshall |
| Toxoplasmosis | 2 | 12 | | Buchanan |
| Tuberculosis, active | 11 | 124 | 125 | Polk |
| Venereal Diseases: Gonorrhea | 478 | 6236 | 6481 | Black Hawk, Johnson, Linn, Polk |
| Syphilis | 24 | 372 | 415 | Linn, Polk |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

Herpes simplex ..... 17 Herpes zoster ..... 5

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# About IOWA Physicians

**Dr. Asa Arent,** Humboldt, was guest speaker at recent meeting of the community's Rotary Club. Dr. Arent discussed his experiences with solar energy. . . . **Dr. M. Lee McClenahan,** Sigourney, has opened an additional office in What Cheer. Dr. McClenahan has practiced in Sigourney since 1970. . . . **Dr. Franco Chua,** Marshalltown, was guest speaker at recent local meeting of ambulance personnel. Dr. Chua discussed emergency care for children. . . . **Dr. Hans Zellweger,** professor, and **Dr. Victor Ionasescu,** associate professor, U. of I., Department of Pediatrics, have been granted $20,000 by Muscular Dystrophy Association of America for neuromuscular research. . . . **Dr. Robert Gitchell** has joined the McFarland Clinic in Ames. Dr. Gitchell, an orthopedic surgeon, received the M.D. degree and completed his residency at U. of I. College of Medicine. . . . **Dr. John H. Faust** has joined the Granger Medical Clinic. Dr. Faust received the M.D. degree at Northwestern University School of Medicine and comes to Granger following 40 years of practice in Huron, South Dakota and Manson, Iowa.

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Three Iowa City physicians were recently admitted to fellowship in American Academy of Pediatrics. They are **Drs. J. M. Cruikshank, Jean E. Robillard,** and **Peter D. Wallace.** . . . **Dr. Dale Harding,** Eagle Grove, president of Iowa Heart Association, attended recent annual meeting of American Heart Association in Dallas, Texas. . . . **Dr. Ronald A. Dierwechter** has joined the Buena Vista Clinic in Storm Lake. A Storm Lake native, Dr. Dierwechter was a Methodist missionary doctor in North Africa for several years. He recently completed additional postgraduate work and surgical training at Broadlawns Hospital in Des Moines. . . . **Dr. Geoffrey N. Marsh,** visiting professor, U. of I. Department of Family Practice, was guest speaker at recent meeting of Johnson County Medical Society. His topic "English Family Practice: A Prejudiced View." . . . **Dr. Ian M. Smith,** professor of internal medicine, U. of I. College of Medicine, has completed a tour of European centers for infectious disease study. While abroad, Dr. Smith spoke at University of Glasgow, Scotland, University of Birmingham, England, and the University of Leiden, The Netherlands.

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The following members of the IMS Committee on Alcoholism—**Dr. S. M. Haugland,** chairman, Lake Mills; **Dr. F. W. Bennett,** Cedar Rapids; **Dr. R. E. Donlin,** Harlan; and **Dr. William C. McCabe,** Bettendorf, were program participants in a November conference on "The Medical and Nursing Management of the Acute Alcoholic" at U. of I. College of Medicine. The U. of I. Alcoholism Center, directed by **Dr. Harold Moessner,** and the Colleges of Medicine and Nursing presented the conference. Co-sponsors were Iowa Academy of Family Physicians, Iowa Hospital Association, Iowa Medical Society and Iowa Nurses' Association. . . . **Dr. William S. Barker** has joined **Drs. B. E. Hoenk** and **M. E. Collentine** in Davenport. Dr. Barker specializes in ear, nose, throat and facial plastic surgery. A 1966 U. of I. medical graduate, Dr. Barker interned at Good Samaritan Hospital in Portland, Oregon and completed his otolaryngology residency at U. of I. College of Medicine.

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**Dr. Robert J. Reed,** Des Moines, was recently presented a plaque from students and faculty of Iowa Lutheran Hospital School of Nursing for his 23 years as Student Health Physician. . . . Recent additions to Des Moines' Iowa Lutheran Hospital staff are—**William G. Bartlett,** D.O., **Shi-Hyo Lee,** M.D., **Saheb Sahu,** M.D., **Walter J. Riley,** M.D., **Thomas M. Altemeir,** M.D., **Richard C. Johnston,** M.D., **James L. Stecher,** M.D., **Al-**

**vin J. Elliott,** M.D., and **Douglas B. Dorner,** M.D. Dr. Dorner is the son of **Dr. Ralph A. Dorner,** Des Moines. . . . **Dr. Charles M. Marriott,** Sioux City, has been granted active membership in the American Society of Therapeutic Radiologists. Dr. Marriott is both a Diplomate and Fellow in American College of Radiology.

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**Dr. James Paulson** has joined **Dr. Bernard Wiltfang** in family practice in Grinnell. Dr. Paulson received the M.D. degree at U. of I. College of Medicine and interned at Broadlawns Polk County Hospital in Des Moines. . . . **Dr. Sidney Brody,** Ottumwa, participated in a recent symposium on sports medicine at Indian Hills Community College in Ottumwa. . . . **Dr. Howard B. LaTourette,** professor of radiology, U. of I. College of Medicine, was guest speaker at recent meeting of Wapello County Medical Society. Dr. LaTourette's topic "Future Prospects of Radiotherapy." . . . **Dr. Susan Woo** has joined Medical Associates in Cedar Falls to do family practice. A graduate of University of Hong Kong, Dr. Woo came to Iowa in 1973 and served a year of residency in family practice at St. Joseph Mercy Hospital in Mason City. . . . **Dr. Melvin G. Bourne,** Algona physician for 43 years, retired January 1. Dr. Bourne received the M.D. degree at U. of I. College of Medicine; served his internship and residency at Harper Hospital in Detroit, Michigan. A native of Algona, Dr. Bourne returned to his home town in 1931. . . . **Dr. Leo J. Miltner,** Davenport, was a U.S. delegate to British Rehabilitation Association meeting in London. Dr. Miltner addressed the group and also served as chairman of the section, Aids to Mobility. Representatives from Europe and British Empire attended the meeting.

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New Wright County Medical Society officers are **Dr. A. M. Nelson,** Belmond, president; **Dr. Glenn Hruska,** Belmond, vice president; **Dr. C. P. Hawkins,** Clarion, secretary-treasurer; and delegate, **Dr. Dale Harding,** Eagle Grove. Alternate delegate is **Dr. S. P. Leinbach,** Belmond. . . . **Drs. Terry F. Dynes,** Decorah, and **H. C. Hallberg,** Oelwein, are coordinating special education programs on basic cardiology for physicians, nurses and allied health personnel in northeast Iowa. The series of programs is sponsored by the MINOWA Area Health Council, U. of I. College of Medicine and Mayo Clinic. . . . **Dr. Raymond Maixner** began medical practice in Logan in January. A graduate of University of Nebraska School of Medicine, Dr. Maixner served an in-

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ternship and residency in Flint, Michigan hospitals. He has practiced family medicine for about 15 years and comes to Logan from Superior, Nebraska. . . . **Dr. D. C. Weideman,** Vinton, has been elected president of the Virginia Gay Hospital Board. . . . **Dr. Paul Gjerstad,** Maquoketa, has been named chief of staff at Jackson County Public Hospital. . . . The Winnebago Council, Boy Scouts of America, have elected **Drs. Richard Bealka** and **Robert Henderson,** both of Independence, to its board.

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**Dr. Pauline V. Moore,** U. of I. student health physician and longtime member of Iowa City's Mercy Hospital medical staff, retired in December. A native of West Branch, Dr. Moore is a U. of I. medical graduate. She interned and served a residency at University Hospitals. . . . The following Cedar Rapids physicians are new officers of CR's Mercy Hospital medical staff—**Dr. John P. Barthel,** president; **Dr. John Puk,** president-elect; and **Dr. Joseph Galles,** secretary-treasurer. Heading St. Luke's medical staff in Cedar Rapids will be **Dr. John H. Lohnes,** president; **Dr. Percy G. Harris,** president-elect; **Dr. Newell G. Ingle,** vice president; and **Dr. Dale D. Morgan,** secretary-treasurer. . . . The Clinton County Medical Society has elected **Dr. Margaret Emmons** president; **Dr. Salvador Borja,** secretary-treasurer. Reelected delegates were **Dr. G. T. Schmunk** and **Dr. G. L. York;** alternate delegates, **Dr. Dale Weber** and **Dr. Robert German.** . . . **Dr. R. Bruce Trimble,** Mason City, was guest speaker at recent meeting of Mason City chapter of AAMA. Dr. Trimble spoke on rheumatology. . . . **Dr. W. J. Neuzil,** retired Cedar Rapids physician, was among past presidents of Mercy Hospital medical staff recognized at recent annual meeting. Dr. Neuzil was the staff's first president in 1921. . . . **Dr. Paul M. Seebohm,** executive associate dean, U. of I. College of Medicine, and **Dr. Donald J. Soll,** Denison, have been reappointed by **Governor Robert Ray** to Comprehensive Health Planning Advisory Council of Iowa.

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**Dr. Charles M. Marriott,** Sioux City radiologist, is new active member of the American Society of Therapeutic Radiologists. Dr. Marriott is both a Diplomate and Fellow in the College of Radiology. . . . **Dr. Max Olsen,** Minden, was recently honored by Creighton University and its Alumni Association. A 1949 graduate of Creighton Medical School, Dr. Olsen was presented a Silver Anniversary Citation recognizing his 25 years' service to mankind and his loyalty to Creighton. . . . **Dr. Joseph Spearing,** Harlan, has been appointed to the Shelby County Commission of Hospitalization. . . . **Dr. Opas Anothayanontha,** Traer, was recently elected a Fellow in American College of Pathology. Dr. Anothayanontha is a certified pathologist in clinical anatomical pathology as well as hematology and nuclear medicine. . . . **Dr. D. M. TanCreti,** Denison, is new president of Crawford County Memorial Hospital medical staff. **Dr. James L. Flood,** Denison, was named vice president; and **Dr. M. U. Broers,** Schleswig, secretary-treasurer. Dr. TanCreti was also named president of Crawford County Medical Society. . . . **Dr. John Hess, Jr.,** Des Moines, has been appointed associate director of Family Practice Department at Broadlawns Polk County Hospital.

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**Dr. John J. Dougherty** is new president of Sioux City's St. Vincent Hospital medical staff; **Dr. Vernon G. Helt** is vice president; and **Dr. Sidney A. Cohen,** secretary-treasurer. All are Sioux City physicians. . . . **Dr. G. T. Schmunk,** Clinton, is filling a vacancy on Clinton Community Board of Education. . . . Retired physicians, **Drs. Cornelius Murphy,** Alton, **Edward Grossmann, Sr.,** Orange City, and **Alexander Bushmer,** Orange City, were honored recently by Orange City hospital employees. During the "This Is Your Life" presentation, each doctor was cited individually and presented a plaque in honor of contributions to health care delivery in the area. . . . **Dr. Dale Weber,** Clinton, was recent guest speaker at Fulton Junior High School. Dr. Weber gave a slide presentation on his experiences working with Dr. Albert Schweitzer in Africa. . . . **Dr. James Rathe,** Waverly, has been re-elected chairman of the Bremer County Health Assembly. . . . **Dr. Juergen Holl,** Clinton, is new medical staff president at Clinton's Mercy Hospital. . . . **Dr. J. E. Daggett,** formerly of Lennox, South Dakota, joined the Hawarden Medical Clinic in January. Dr. Daggett received the M.D. degree at U. of I. College of Medicine.

## DEATHS

**Dr. Abraham E. Berry,** 67, Oelwein, died at his home December 9. Dr. Berry received the M.D. degree at University of Arkansas School of Medicine and served his residency in ophthalmology at Metropolitan Hospital in New York City. Prior to coming to Oelwein in 1957, Dr. Berry was a pharmacist and staff physician at Newart Eye and Ear Hospital in New Jersey. He was a member of American Board of Ophthalmologists and American Academy of Ophthalmology and Otolaryngology.

**Dr. Melvin H. Bloom,** 49, Des Moines, died at his home December 9. Dr. Bloom, a surgeon at Veterans Hospital, received the M.D. degree at U. of I. College of Medicine and was a lifelong resident of Des Moines.

**Dr. Warren H. Foster,** 80, a Clinton physician for 52 years, died January 4 in Midland, Texas. Dr. Foster received the M.D. degree at U. of I. College of Medicine; interned at New Haven Hospital in New Haven, Connecticut and served his residency in ophthalmology at University Hospitals in Iowa City. He was a Life Member of Iowa Medical Society.

## INDEX TO ADVERTISERS


Burroughs Wellcome Co. ..... 50A
Flint Laboratories ..... 74A, B
Geigy Pharmaceuticals ..... 46A, B
Iowa Trust Association ..... 69
Lilly, Eli, & Company ..... 41
McNeil Laboratories ..... 65
Medical Protective Company ..... 72
Milwaukee Sanitarium Foundation, Inc. ..... 70
Pharmaceuticals Manufacturers Association ..... 50B, C
Prouty Company ..... 75
Roche Laboratories ..... 42-43, 54-55, 60B, C, 79-80
Roerig, J. B., & Co. ..... 50D
Searle, G. D., & Co. .....60, 60A
Smith, Kline and French ..... 60D
Webcon Pharmaceuticals ..... 63
World Wide Health Care Air Force ..... 73



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• **Past President's Thoughts** — Page 87
• **National Health Insurance** — Page 88
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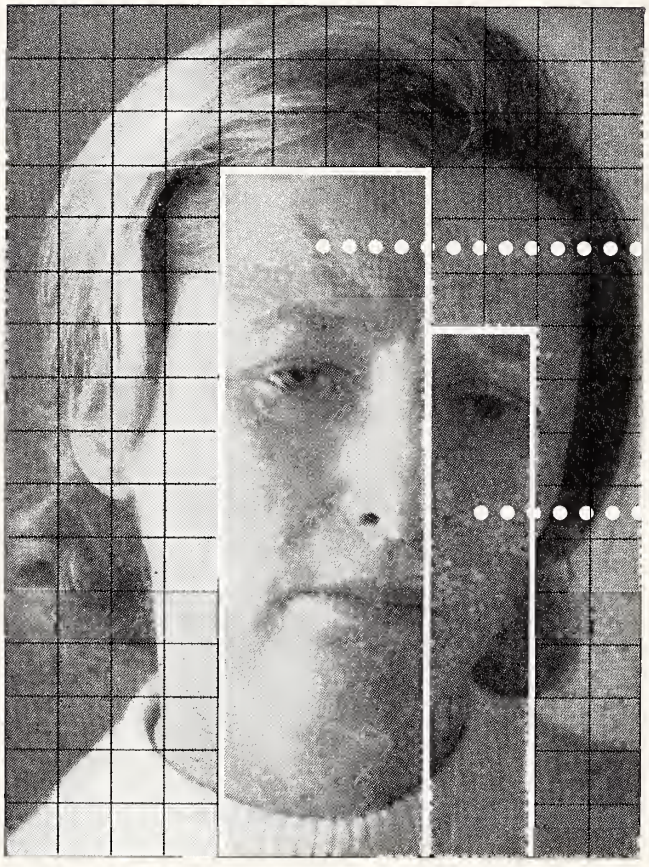
MARCH 1975

# Both often

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# respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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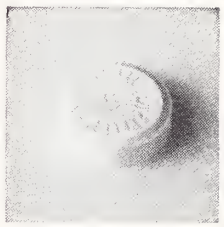

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in psychoneurotic anxiety states with associated depressive symptoms

urveillance because of their predisposition to habituation and dependence. In regnancy, lactation or women of childearing age, weigh potential benefit gainst possible hazard.

**recautions:** If combined with other psychotropics or anticonvulsants, consider arefully pharmacology of agents employed; drugs such as phenothiazines, arcotics, barbiturates, MAO inhibitors nd other antidepressants may potentiate s action. Usual precautions indicated in atients severely depressed, or with latent epression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# President's Page

It's been my privilege to observe the changes in medical practice for 40 years. The rapid acceleration of these changes the past 10 or 15 years has intensified my interest in continuing medical education (CME).

The current activity of the IMS Committee on Medical Education and Hospitals is extremely important. The Committee is studying and helping develop CME mechanisms to support Iowa physicians and assure them of being in compliance with whatever governmental CME requirements may be imposed.

Representatives of the Board of Medical Examiners and U. of I. faculty have met with the Committee (as has a Legislative Study Committee) to develop recommendations relating to the renewal of a physician's license. Receiving and properly recording CME attainment by individual Iowa physicians constitutes a massive administrative undertaking. The Board of Medical Examiners is not presently in a position to perform this task. The Iowa Medical Society, with possible support from the AMA, could function quite logically as the recipient of CME data from individual physicians and could record the credits appropriately.

In addition to efforts having to do with facilitating CME documentation, the Committee on Medical Education and Hospitals is progressing nicely toward achieving status as the authorized state arm of the AMA to accredit institutions (excluding the University) and organizations offering CME programs. A report on this activity will be presented to the 1975 House of Delegates.

Flexibility has been the watchword in the consideration of CME. The net effect of any innovations in this area should be that of fostering incentive and personal satisfaction for the physician. The Society's efforts have been and will be in that direction.

Sincerely,

Ralph L. Wicks

*Ralph L. Wicks, President*

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# IOWA Medical Miscellany

**NOMINATING COMMITTEE . . .** The 1975 IMS Nominating Committee will meet Sunday, March 23, at Society headquarters. District representatives to the Nominating Committee have been selected in caucuses. Nominees for 1975-76 will be chosen for president-elect, vice-president, secretary (3-year term), treasurer (3-year term), speaker, vice-speaker, trustee (3-year term), AMA delegate (2-year term), councilors (3rd, 5th and 10th districts—3-year terms), and Blue Shield Liaison Delegates to IMS.

**PROFESSIONAL LIABILITY . . .** Efforts to alleviate professional liability insurance problems hold IMS priority status. Legislative activity is progressing in line with recommendations made by the Medico-Legal Committee and approved by the Executive Council. Legislation pertaining to peer review immunity, statute of limitations and contingency fees, etc. is being pursued. In addition, exploration of a group coverage program for Iowa physicians is underway with Rollins Burdick Hunter Company, insurance brokers. February discussions have also been held with State Insurance Commissioner William Huff.

**LEGISLATIVE BULLETIN . . .** February Bulletin stressed the grave public consequences of the professional liability problem, i.e., scarcity of coverage is preventing establishment of new practices, patient care costs are increasing to cover high premiums, etc. Discussion of these matters with state legislators was encouraged.

**MARCH INFO SESSIONS . . .** Info sessions for Iowa physicians occur this month at five sites: March 12—Atlantic; March 13—Spencer; March 19—Amana; March 20—Waterloo; and March 26—Des Moines. Agenda topics include professional liability, PSRO, state legislation, hospital/medical staff relations, AMA dues. Programs have been sent to IMS members. Further details may be obtained from Society headquarters.

**HEALTH PLANNING . . .** Study committee formed by Governor Ray to consider new federal law imposing health planning requirements includes IMS representative. Primary consideration will be given to number of health service areas to be recommended for Iowa. IMS Executive Council has recommended a single statewide area. This action was taken knowing sub or local areas have input opportunities. John Tyrrell, M.D., Manchester, will represent IMS on Governor's committee.

**UCR PAYMENTS . . .** Recent Blue Shield reports indicate approximately 95% of claims filed under UCR program are being paid as filed.

**PERINATAL CARE . . .** Annual meeting of Great Plains Organization for Perinatal Health Care will be May 19-20 in Bloomington, Minn. Iowa health professionals involved in perinatal care are welcome. Further info is available from H. A. Hein, M.D., director, Statewide Perinatal Care Program, Iowa City (319/356-2637).

**HAWKEYE SCIENCE FAIR . . .** Annual opportunity for Iowa junior high and high school students to display their scientific prowess will occur April 11-12 at the Veterans Auditorium in Des Moines. IMS and Scanlon Medical Foundation are HSF co-sponsors with Drake University and the DES MOINES REGISTER & TRIBUNE.

**HOUSE OF DELEGATES . . .** Plans for April 30/May 1 IMS House of Delegates are moving forward. Participants will include Mrs. Mary Louise Smith, Chairman, National Republican Party, and Malcolm Todd, M.D., AMA President.

**LIAISON . . .** The Iowa Physician's Assistant Society has requested a formal liaison be created between it and the IMS. The Board of Trustees has requested the Committee on Interprofessional Activities serve as the Society's principal link.

*(Please turn to page 104)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

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MARCH, 1975

## TABLE OF CONTENTS

Stereotaxic Hypophysectomy
S. Okawara, M.D. . . . . 97

Congenital Malformations Associated with Myelomeningocele
Spencer F. Brown, Ph.D., M.D. . . . . 101

### EDITORIALS

March Meetings . . . . . 107

Right or Wrong . . . . . 107

### SPECIAL DEPARTMENTS

President's Page . . . . . 84

Iowa Medical Miscellany . . . . . 85

Question Box . . . . . 87

In the Public Interest
On National Health Insurance . . . . 88

State Department of Health
Emergency Medical Service . . . . 109
Influenza 1974-75 . . . . . 110

Educationally Speaking . . . . . 112

Medical Assistants . . . . . 115

### MISCELLANEOUS

Specialty Briefing . . . . . 112

Scientific Program . . . . . 113

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# The Question Box

by OTIS D. WOLFE, M.D.

*Dr. Wolfe is a past-president of the Iowa Medical Society. He also headed IMPAC for several years. He practices ophthalmology in Marshalltown.*

**How do you assess the medical care environment as we enter the last quarter of the 20th century?**

Two giant imponderables menace the horizon, NHI and malpractice. The Congress may delay NHI until 1976 for political purposes. Timing is important. Major health legislation is usually preceded by a flurry of books and magazine articles and television extravaganzas deploring the nation's health. The Watergate trial has preempted such propaganda. Also, the Democrats may wait until 1976 in the hope of taking full credit for a far-reaching NHI bill. We need catastrophic coverage now but this would neutralize the appeal for broader legislation. A pluralistic system would appeal to more physicians and patients but the government planners like HMO's. The same is true of financing. AMA's Medicredit would be less costly and more efficient than Kennedy type legislation but the Liberals who dominate the 94th Congress may prefer the bureaucracy of the public sector.

Malpractice settlements are incredible. The odds between a standard medical or surgical fee and the liability for error or miscalculation are too great. No longer may physicians reassure their worried patients. Even expressed optimism is penalized severely. Something has to give. Physicians cannot be held responsible by themselves for all calculated risks. New discoveries in pharmaceuticals will also suffer. Probably no change will take place until the public begins to suffer.

**As you read the signs, with national health insurance appearing more imminent, are you pessimistic, optimistic, or what, about the future for the medical practitioner and his patient?**

The middle class concept of physician-patient relationship isn't necessary to all physicians or all patients. More important to the average patient is the availability and economics of his medical care. To the physician, the medical environment is a major priority. The degree of pluralism is going to be important. Not all physicians or patients are suited to group practice. The absence of a pluralistic system will also attract a narrow breed of medical student. Whatever the system, both the patient and physician can expect annoying and even stifling controls. Not everyone will be able to tolerate this, but economics will force almost everyone into the system.

**In this era of consumerism, should effort be continued to maintain—as fully as possible—the physician's position as captain of the health care team?**

The physician is severely handicapped in trying to maintain leadership in health care programs. He doesn't have adequate time to read and digest all the regulations. He can't budget his time so as to attend the necessary meetings. Federal programs are increasingly oriented to consumerism and committees are usually weighted against the physician. Nonetheless, physicians should make every effort to maintain leadership which they may do because of their background and because their opinions carry weight with most lay people.

**What posture do you suggest the Iowa physician assume to confront the future—militant, cooperative, aggressive, informed, or what combination?**

*(Please turn to page 93)*

# ON NATIONAL HEALTH INSURANCE

MANKIND HAS FACED heavy challenges through the centuries. The response has included successes and failures. We have made fantastic progress on many fronts. And we have had noteworthy difficulty in many other areas. Obviously, any historical evaluation involves individual perspective; what some observers call achievement, others label as failure.

The challenges to society remain most apparent as we enter the final quarter of the twentieth century. We have great national and world problems: the solutions to inflation and recession, the prudent retrieval and use of energy resources, the production and distribution of foodstuffs, and so on.

### PROVISION OF HEALTH CARE

The provision of adequate health care is a concern of our time. The health and well being of the population is essential. However, the degree to which the availability and financing of health care is regarded as a problem by the public seems often to be over-estimated or exaggerated. In a Louis Harris poll, commissioned by the U. S. Senate, 64% of those questioned listed inflation as our most serious national problem. Health care rated 15th, or next to last on the list, with only 3% of the respondents putting emphasis on it.

Nonetheless, concerned Iowans and Americans desire and deserve quality health care for themselves and their families. Today's pluralistic American health care system is providing quality services in unprecedented fashion. Iowa statistics relating to life expectancy, infant mortality, communicable diseases, etc., are testimony to the progress which has been made in preserving health and extending life.

### BELIEFS OF MEDICAL PROFESSION

It is a conviction of the medical profession that no citizen should lack adequate medical and health care because of economic, social or any other reasons. This declaration is supported by the following excerpts from policy adopted by the 1969 American Medical Association House of Delegates:

> **"It is a basic right of every citizen to have available to him adequate health care; it is a basic right of every citizen to have a free choice of physician and institution . . . ; the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person . . . for the poor should not be disassociated from, but rather should be a vital part of, the over-all health care system."**

This constitutes the goal of the medical profession: To assure that high quality medical and health care is available to every citizen. This means the poor should have their needs fully met. Too, it is acknowledged that financial hardship imposed by a catastrophic illness may be extremely severe. Persons of moderate to good income can be left financially drained by a long and serious illness. Supportive provisions are needed in these catastrophic situations. Private health insurance is aiding a high percentage of Iowans. In addition, federal/state government is providing health care financing for many other Iowans. Still, it is acknowledged that ongoing evaluation of needs and programs is important if we are to assure that sound ways and means exist for providing broadly based, high quality health care.

Iowa doctors—individually and organizationally, through the Iowa Medical Society—are vitally concerned and seriously involved in activities to ensure the quality of medical and health care, to increase the number of physicians and allied health professionals, and to improve the distribution of manpower so everyone has access to the kind of health care they need. So saying, this does not diminish the medical profession's basic belief in individual responsibility; that it is, in the first instance, the task of the individual to seek out and support his needs and to exercise reasonable cau-

# IN THE PUBLIC INTEREST

tion and judgement in the lifestyle he and his family follow.

## NATIONAL HEALTH INSURANCE

National Health Insurance (NHI) has been a topic of discussion for many years. In these discussions, comparisons are frequently made between the United States and countries with nationalized health programs. These kinds of comparisons must be undertaken in depth to be meaningful. Findings support the fact that the pluralistic American system is equal or superior to any other.

The idea of NHI has gained much momentum in recent years. Its arrival on the U. S. and Iowa scene is forecasted within the next several years by many observers. Its arrival and its structure have definite political implications.

There are approximately 20 different NHI proposals now in existence. They have been subjected to review by the U. S. Congress—and by the medical profession. They vary widely in their range and scope.

For example, some NHI plans would pay all medical bills; others would have NHI share expenses with the patient. In some instances, the patient's share would be scaled according to his ability to pay.

Some plans have tended to protect people mainly from the catastrophic expenses of severe or extended illness; others would cover both catastrophic and ordinary medical expenses. Some would place responsibility for people's health care entirely in the hands of government; others would prefer the private sector to do the job, with varying degrees of government involvement.

## IMPORTANT FACTORS

Most people tend to agree that National Health Insurance ought to focus on the needs of the poor and chronically ill; ought to cover catastrophic medical expenses at the least; and ought to be based in the private sector, although some government involvement is desirable.

It is important to remember the nation pays more than $80 billion for health care—or about $375 per person per year. This sum—and very likely more—will be required in a National Health Insurance program regardless of whether it comes from higher taxes, from privately negotiated programs involving employers, employees, providers of service, etc.; or from a combination of these.

*Factors bearing on National Health Insurance are assessed with emphasis on the Medicredit concept. This discussion was accepted by the Iowa Medical Society Board of Trustees and presented to the Society's Executive Council January 30, 1975.*

Persons interested in health care delivery should understand something of the dynamics. There are three basic elements involved. First is the matter of access; it is society's desire to make medical care available to all. Secondly, there is the desire and need to control cost. As new capabilities (technology, medications, human skills) for delivering care appear, the cost of services has increased. The third factor is the desire for high quality. Each of these has an important impact on the other two, on the totality of health care delivery, and on the proposition of National Health Insurance.

When entry to the health care system is totally open to the full population with no restraint whatsoever and very tight cost controls are imposed, the prospects for high quality are jeopardized. Available health manpower is overtaxed by the well and worried-well, as well as the sick. As a result, the important quality element suffers.

Similarly, if the factors of total access and maximum quality are stressed, this combination threatens cost containment. It is not possible to provide the highest quality service to the full population under a cost containment policy.

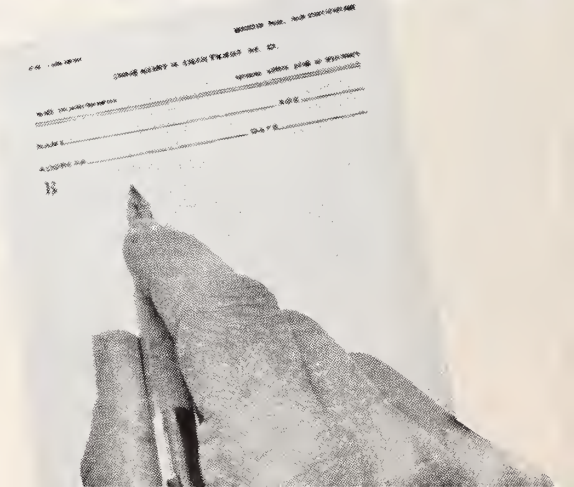
Finally, if emphasis is on high quality and cost control, then there is resulting pressure on access to the system. When stringent cost restrictions are imposed with a corresponding all-out emphasis on quality levels, the ability to handle the heavy demand becomes more acute.

This oversimplified discussion is meant to demonstrate the complexity of health care delivery and to show that the consideration of National Health Insurance is a demanding proposition. It should honestly be admitted that the perfect health care system—blending the factors of universal access, low cost and high quality—will never be fully achieved but improvements are attainable.

## MEDICAL PROFESSION PROGRAM

The health care system in the United States has served a widely-dispersed population with distinction. Its ability to deliver high quality care

# Bioequivalence



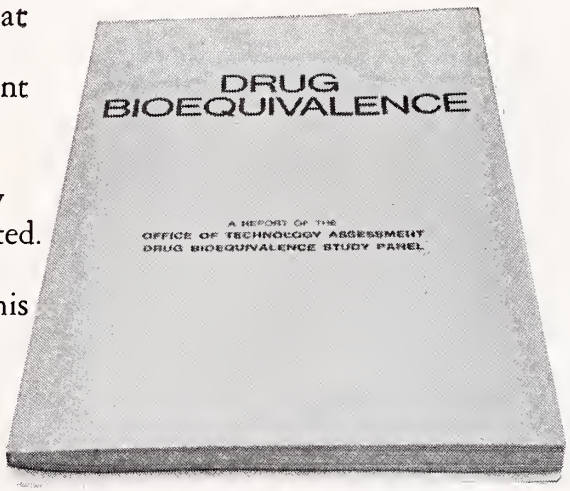
# the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.




"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and (b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

# protecting the integrity of your prescription

## IN THE PUBLIC INTEREST

is respected worldwide. It has been and needs to be flexible, innovative and responsive to the need for change and improvement. Our facilities must continuously expand and improve. Our medical manpower—physicians and other professionals—must continue to increase.

We must strive for improvement; however, as practicing physicians, we are of the opinion the desired goals will be best achieved through endeavors incorporating and building upon the very real strengths of our system. Our medical system should retain the flexibility and freedom of choice philosophy so necessary to innovation, to evolution, to experimentation.

Some proposals before the U. S. Congress would completely restructure the present system in favor of concepts which are untried and of questionable promise. Government domination of health care delivery is characteristic of such proposals. Such domination or restructuring is neither desirable or justified.

### MEDICREDIT—A SOUND APPROACH

The medical profession has developed a National Health Insurance program which is popularly named, "Medicredit." It has been submitted to the U. S. Congress and its legislative sponsors exceed 100 to outnumber those endorsing any of the other proposals.

Medicredit is a program which allows every person in Iowa and the United States equal access to high quality medical and health care regardless of ability to pay. It is a three-pronged approach to providing health insurance protection. (1) It will pay the full cost of insurance for those too poor to support their health care needs; (2) It will help those who can afford to pay a part of their health insurance cost. The less they can afford to pay, the more the government would pay; (3) It will see to it that no American has to bankrupt himself because of a catastrophic illness.

Under Medicredit the government will pay all of the premium for low-income people—the individual (and his dependents) who has no income tax liability. For others, the government will pay between 10 and 99% of the Medicredit premium based on the family or individual income. It will pay everyone's premium for catastrophic expense coverage.

Coverage under Medicredit may be elected by the individual. It may be in the form of a health policy from a qualified insurance company. It may be as a membership in a prepayment plan such as Blue Cross/Blue Shield. Or it may be as a membership in a health maintenance organization (HMO).

An approved policy will offer comprehensive insurance against the ordinary and catastrophic expenses of illness. Preventive care will be stressed, to include physical exams, well-baby care, inoculations, and x-ray and laboratory work in or out of the hospital. Basic benefits in a 12-month period will include 60 days of hospital care or 120 days in a skilled nursing care facility.

Other basic benefits include emergency and out-patient services and all medical services provided by physicians. Also covered are home health services, dental care for children, and emergency dental services for all.

The catastrophic expense protection will pay expenses in excess of the basic coverage, including hospital, skilled nursing care, in-patient drugs, blood, prosthetic appliances, and other specified services, including physicians.

Any insurance policy, prepayment plan or membership group offering as many benefits as those offered by Medicredit's approved programs will need financial safeguards. These safeguards are almost always in the form of deductibles (or co-insurance)—amounts the patient pays before the program itself begins to meet expenses.

There will be a deductible of $50 per hospital stay, and 20% co-insurance (maximum $100 per family per year) on medical expenses, emergency or out-patient expenses and dental services. Under the catastrophic illness provisions, the amount of the "financial corridor" would be 10% of the previous year's taxable income reduced by the total deductibles and co-insurance incurred under the basic coverage.

A beneficiary eligible for full payment of premium by the federal government would receive a certificate to present to the health care insurance program desired for himself and his dependents. Eligible beneficiaries with whom the government will share the cost of premium may elect a credit against income tax or a certificate.

To participate in the Medicredit program, an insurance company or a prepaid group would have to qualify under state law, provide certain basic coverage, make coverage available without

regard to pre-existing health conditions and guarantee annual renewal.

SUMMARY

In its extended consideration of the National Health Insurance programming, and its development of the Medicredit proposal, the medical profession has emphasized that various principles should be embodied in Medicredit or any NHI proposal. These include: minimum federal involvement in administration; state jurisdiction over the licensure of physicians and regulation of insurance; minimum federal dollars in financing of programs for comprehensive coverage at least possible cost; funding through federal revenues, state and private funds including (a) employer/employee contributions for private health insurance, and (b) an individual tax credit as applied for full health care protection; no added Social Security tax for financing; no Social Security administration of the NHI program; cost sharing by participating individuals and families and a subsidy for the indigent scaled according to income; use of private insurance on a risk and underwriting basis; comprehensive coverage, basic and catastrophic, for the entire population; pluralism in methods of health care delivery; appropriate cost and quality controls; continuity of benefits; separate professional and institutional accounting; and coordination of benefits.

The Iowa Medical Society—representing the medical profession—recommends the principles of Medicredit as being best suited to fulfilling the needs of society. It is a sound concept which will allow the health care industry to serve the population in Iowa and the nation. We invite and encourage support for the Medicredit blueprint.

## QUESTION BOX

*(Continued from page 87)*

Perhaps one word says it all . . . understanding. Much bad medical legislation results because physicians don't understand the political process any better than politicians understand the practice of medicine. All politicians have one thing in common; they are very sensitive and responsive to their supporters. There are no vacuums in politics. If physicians don't participate in the political process, someone else will do it for them, and both physician and patient are losers when this happens. Socrates said, "Get involved in politics or be ruled by your inferiors."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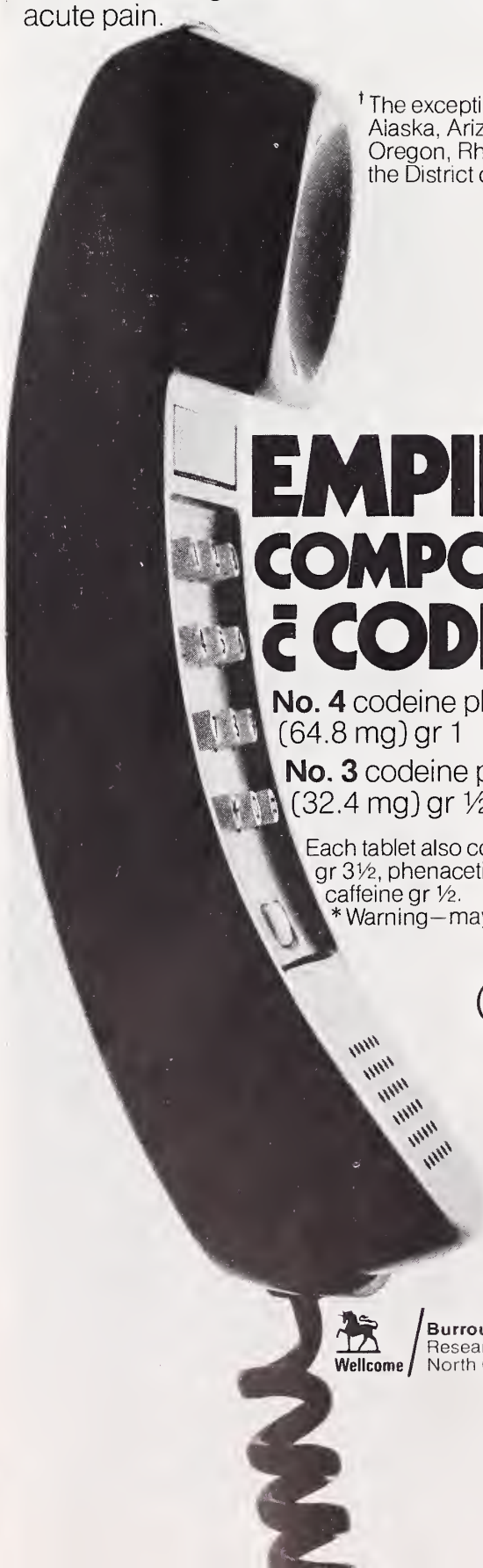
† The exceptions: Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia.



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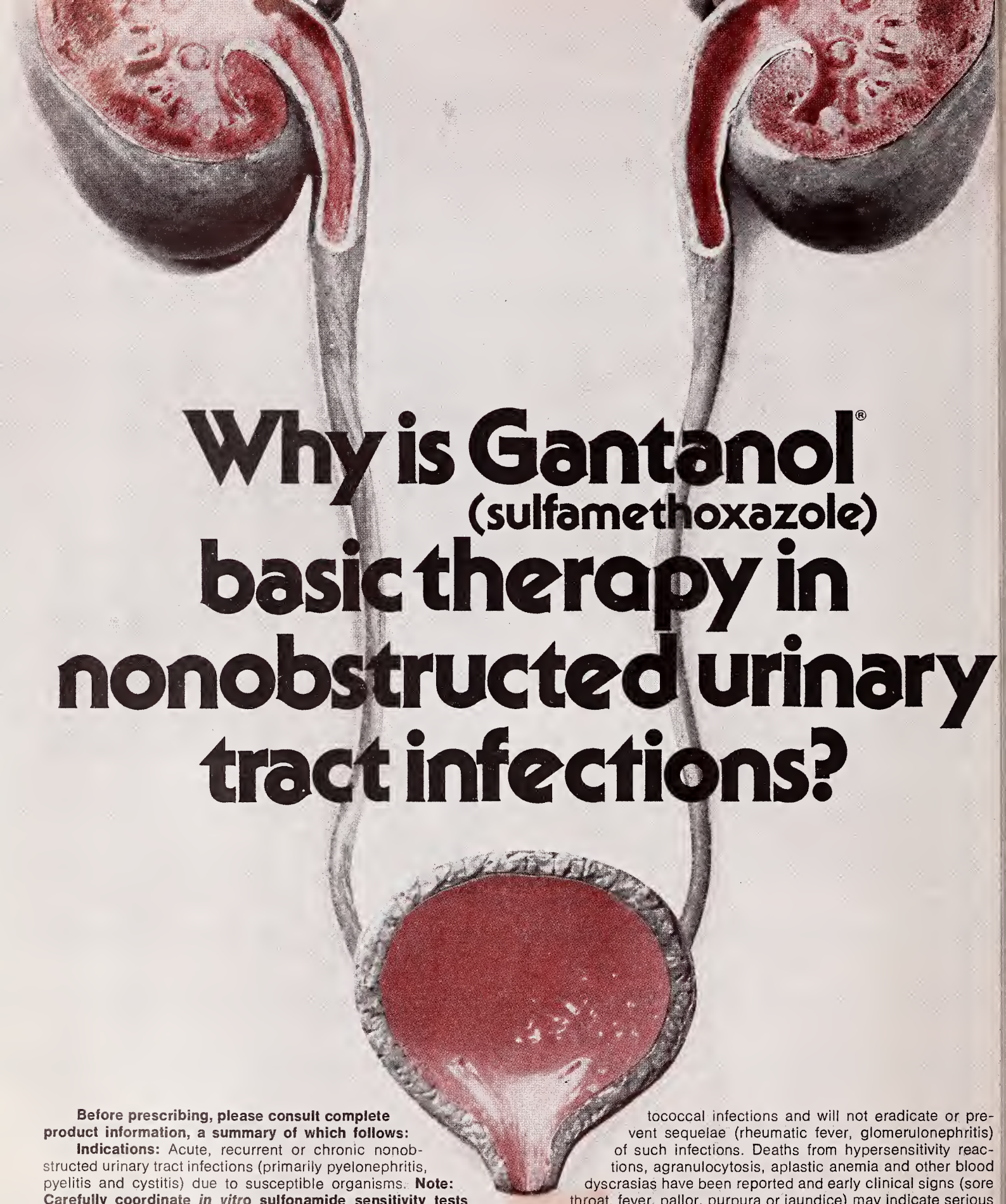

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SCIENTIFIC ARTICLES

# Stereotaxic Hypophysectomy

S. OKAWARA, M.D.
Iowa City

*Stereotaxic operation of the pituitary gland has virtues. The author regards it as safer and a less invasive surgical procedure than conventional craniotomy.*

THE FIRST intracranial operation on the pituitary gland was performed in 1896 by Sir Victor Horsley. Horsley was a pioneer of experimental stereotaxic techniques in England.

The first stereotaxic-approach to the gland was performed ironically in 1921 by Oscar Hirsch,[8] a prominent Viennese otolaryngologist. To treat pituitary adenoma, Hirsch designed a simple device which attached to the patient's teeth and held a radium capsule within the sphenoidal sinus under the fenestrated sella turcica.

As the place of hypophysectomy became secure in the treatment of pituitary hyperfunction and hormone dependent cancers, e.g., breast and prostate, an operative method for pituitary ablation was sought. The goal was a maximally effective and safe procedure, minimally invasive to the patient.

Dr. Okawara is an associate professor in the Division of Neurosurgery at the University of Iowa College of Medicine.

The first credit for modern stereotaxic operation upon the pituitary gland should be given to Talairach and his colleagues at Hospital Sainte Anne in Paris.[17] In 1955, they placed a one millimeter cannula into the sella turcica by means of their own stereotaxic apparatus and introduced numerous destructive agents into the gland. This method gained popularity within a short period in many medical centers. Numerous radioactive materials were used, and soon radioactive gold ($Au^{198}$) and yttrium ($Y^{90}$) were recognized for their superiority over radium, radon, etc.[6]

In 1955, Rasmussen and Harper[16] at the University of Glasgow, following their observation of its favorable results in suppressing growing tumor and pain in breast cancer patients, emphasized the superiority of $Y^{90}$ for pituitary gland ablation.

As stereotaxic implantation of $Y^{90}$ proved its practical value for palliation of breast and prostate cancer, disadvantages developed, including migration of isotope pellets, bone erosion and consequential cerebrospinal fluid rhinorrhea caused by using the freely moving pellet form. These were corrected by Forrest's rod of $Y^{90}$ prepared by the same group in Glasgow.[4] In this rod the isotope or isotopes are accommodated in a nylon capsule with a metallic screw. This screw part remains in the bony wall of the sella, fixing firmly the isotope capsule and sealing the bony fenestration. Thus, its migration and the cerebrospinal fluid rhinorrhea, which usually occurs two weeks following its application, were prevented.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MARCH, 1975.

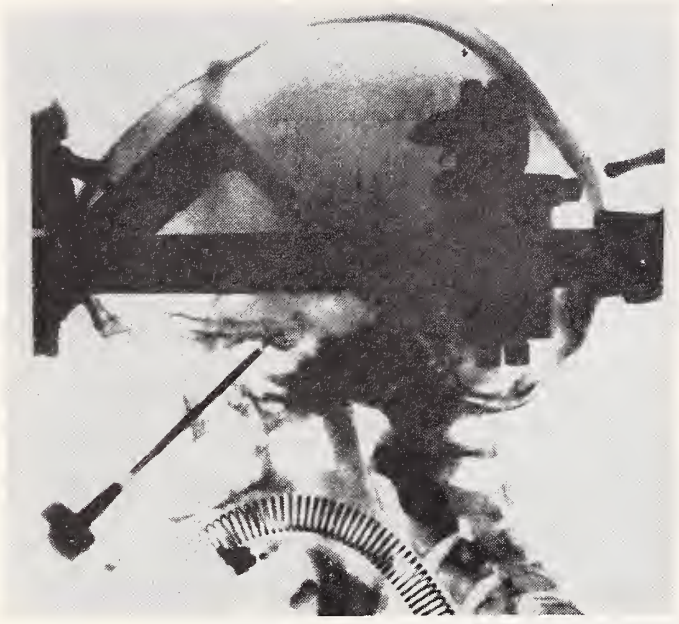

Figure 1. Lateral roentgenogram shows the stereotaxic base ring applied to the patient's head and the electrode with its tip in the sella turcica via trans-sphenoidal approach. The electrode is inserted through 2 mm bony holes into the sella turcica according with the target coordinates from the 0-point in the base ring.

Dosimetric calculation for the sellar dimensions decides isotope quantity and positions of the rods in the sella turcica.

However, these methods of pituitary ablation with implanted radioactive isotopes, including the improved screw-rod, have presented further problems: 1) uncertainty of complete hypophysectomy at radiation levels free of complications in spite of accurate prospective calculations, 2) late radiation damage to the optic and oculomotor nerves, 3) late cerebrospinal fluid rhinorrhea, 4) significant abscess and meningitis, and 5) the possibility of radiation contamination during and after operative procedures.

Alternative methods to ablate pituitary function without radioactive isotopes have been sought simultaneously. Cryonecrosis (necrosis by extreme cooling down to –60° to –90° C) of living tissues was originally used by Hass and Taylor in 1948.[7] Successful creation of small discrete lesions of animal cerebral tissue by Tytus and Ries in 1961 soon brought its application to human brain tissue by Cooper in 1963.[2, 18] He applied this cryonecrosis by a liquid nitrogen probe placed via a stereotaxic transfrontal approach to the pituitary gland. However, the transfrontal stereotaxic approach to the pituitary gland was soon found to carry some complications because of its pathway at the vicinity of the optic chiasm and hypothalamus.

In 1964, Rand[15] employed this cryogenic lesion using a transphenoidal stereotaxic method and obtained more safe and satisfactory results.

In 1965, Zervas[20] used high radio-frequency thermal coagulation of the pituitary gland through a stereotaxic trans-sphenoidal approach. He reported that his pathology specimens proved complete ablation of the pituitary gland. The cerebrospinal fluid rhinorrhea through the perforation of the bone structures was prevented by the plastic or metallic screw plugged into the perforation.

## PROCEDURE

The patient is prepared for two to three days before the procedure by hair and nasal hygiene.

The operation is performed usually under topical anesthesia with an endotracheal tube in or general anesthesia to secure an airway.

The stereotaxic ring frame is applied to the patient's head, and the frame is attached to the x-ray table. Lateral and frontal films are taken. The lateral film supplies the necessary coordinate distances from the 0-point of the frame to the sella turcica, and the frontal film gives the lateral distance from the sagittal line to the target in the sella turcica.

Following determination of the approach pathway (transfrontal or transnasal-sphenoidal), an appropriate small twist-drill hole of the bone is made on each side of the midline for needle entry.

The depth calculated from x-ray films is reached by the electrode of 2 mm thickness for coagulation; the ejector cannula can be used for isotope ablation or the cryoprobe for cryonecrosis (Figure 1). Following removal of the cannula the perforation is plugged with a metallic or plastic screw or simply with a mixture of gelfoam and bone wax. Epistaxis can be troublesome but is controlled with nasal packing for 24 hours. Prophylactic antibiotics are given.

*Application of stereotaxic pituitary ablation*

Pituitary ablation is indicated for one of the following:

1. Inhibition of hyperpituitarism such as acromegaly, Cushing's disease, and exophthalmus.
2. Ablation of normal pituitary functions to modify the endocrine environment for treatment of hormone-dependent tumors.
3. Arrest of vascular complications of diabetes mellitus and malignant hypertension.

The stereotaxic approach to the gland should be considered by its following advantages:

1. Minor but accurate surgical procedure.
2. Biopsy for tissue diagnosis.
3. Intrasellar decompression.

This method is not indicated for a pituitary tumor which extends out of the sella turcica and compresses the optic chiasm, carotid artery and hypothalamus or which erodes bone structures of the surrounding sinuses. Also, this method is contraindicated for patients with severe hypoglycemia caused by islet cell tumor of the pancreas, as suppression of human growth hormone will result in a more severe hypoglycemic condition.

1. *Hyperpituitarism*

The soft tissue changes in the acromegalic patient occur almost immediately after the pituitary operation. Moreover, recent progress in quantification of human growth hormone by radioimmuno-assay has greatly contributed in evaluating the result of pituitary surgery, making it possible to follow postoperative pituitary function more accurately. Results produced by each method of pituitary ablation previously described have accumulated. Concerning $Y^{90}$ implant, Kaufman's group[11] reported a 66% decrease of plasma growth hormone, while cryogenic operation showed 59% (Maddy)[13] and radiofrequency, 54% decrease (Zervas).[19] Therefore, it can be concluded that any stereotaxic trans-sphenoidal approach produces an approximate 60% decrease of plasma growth hormone level within two to three years.

2. *Hormone dependent cancers*

*Breast Cancer:* In 1952, Huggins and Bergenstal[9] showed that adrenalectomy could produce remission in certain patients with metastasis from breast and prostatic cancer. In the following year Luft and Olivecrona[12] published their experiences with hypophysectomy in 12 patients with metastatic carcinoma, and their later report in 1957 indicated objective palliation in 47% of patients.[10]

In 1956, Anderson[1] acknowledged the effect of hypophysectomy especially on pain and suppression of growth of metastatic breast cancer. He also observed increases of body weight of such terminal cancer patients as well as improvement in their hemograms. Fifty-seven per cent of his 47 cases showed remission periods ranging from 14.7 to 16.9 months following hypophysectomy.

In 1965, Edelstyn and his associates[3] set indications of hypophysectomy for metastatic breast cancer based on their careful clinical survey. They stated that careful selection of patients and assurance of complete ablation of gland function could increase the remission rate further.

The prognosis for remission after hypophysectomy is better when signs of tumor recurrence occurred two or more years after the primary diagnosis was made and in patients over age 40. A good response to estrogen also predicts a favorable result to pituitary ablation. Remission is more likely for skin and bone than liver metastases.

It is generally agreed that the remission rate is 30-35% and relief of pain from osseous metastases is also 30% (based on criteria set by the American College of Physicians and College of Surgeons Joint Committee).[14]

*Prostate Cancer:* Benefit from hypophysectomy in patients with metastatic prostate cancer was initially reported by Luft and Olivecrona (1953).[12] Palliation of pain, suppression of expansion of bone metastases and prolongation of life expectancy have been reported by these authors.

*Cancer of Ovaries, Uterus, and Testis:* Excepting chorioepithelioma, benefits of pituitary ablation on the metastases from these reproductive organs are controversial.

3. *Vascular Complication of Diabetic Retinopathy and Malignant Hypertension*

*Malignant Diabetes:* Pituitary ablation for malignant diabetes was suggested by the "Houssay-phenomenon" (1930): that the secondary diabetes induced by pancreatomy is abolished by ablation of the anterior lobe of the pituitary gland. Zervas reported that insulin requirements decrease more than 50% in one-quarter of patients.[19]

In the International Symposium on Diabetic Retinopathy in 1968,[5] it was the general conclusion that hypophysectomy was effective in suppressing proliferative hemorrhagic diabetic retinopathy. Approximately 80% of patients showed some visual improvement or arrest of the progressive pathology.

The patient should be selected for surgery who has progressive proliferative hemorrhagic retinopathy. Blindness and retinal detachment should exclude the patient from surgery.

*Malignant Hypertension:* Luft and Olivecrona (1953)[12] described improvement of vascular changes in malignant hypertension after hypophysectomy, especially in young patients. Pathology in the optic fundi, kidney function and myocardial changes can be improved.

However, because of the increased operative complications and poor tolerance of patients to the consequential pituitary insufficiency, this treatment modality is still controversial.

Indications for these stereotaxic methods of pituitary ablation may well be expanded in the future in combination with other targets outside the pituitary gland.

## SUMMARY

Stereotaxic operation of the pituitary gland is a safer and less invasive surgical procedure than conventional craniotomy. Its indications include: 1) pituitary hyperfunction, 2) hormone dependent malignant tumors such as breast and prostate cancer, and 3) vascular complications of malignant diabetes and hypertension.

## REFERENCES

The references noted in this article may be obtained from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

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*Adverse reactions:* Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

*Dosage and administration:* ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

*Overdosage:* Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

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# Congenital Malformations Associated With Myelomeningocele

SPENCER F. BROWN, Ph.D., M.D.
Darien, Connecticut

*Iowa study of 434 patients with myelomeningocele showed 82.7% with at least one additional malformation. More females had an associated defect. Only defects more prevalent among males were genitalia and inguinal hernia.*

It is generally believed that congenital malformations tend to be multiple. Objective studies on this matter are somewhat conflicting. In their meticulous study of congenital malformations in nearly 6,000 pregnancies, McIntosh *et al.*[1] found an overall incidence of 7.0% among live-born infants surviving the neonatal period. The incidence among males was 8.4%; among females, 5.5%. Of all these malformed live-born infants, 14.8% had more than one malformation. Ingraham and Swan[2] found 570 associated malformations in 232 patients with spina bifida or cranium bifidum. This is an average of 2.46 associated malformations per patient. Their entire series include 546 cases, and they do not state on what basis the 232 cases were selected for the survey of co-existing anomalies. Schwidde[3] reviewed 225 cases of spina bifida including encephalocele and presents data on associated malformations in 100 of these. Again, it is not stated on what basis the 100 cases were selected from the 225 total. Schwidde lists 217 associated malformations, or an average of 2.17 per patient, but excluded clubfoot, dislocated hip, and hydrocephalus for unstated reasons.

This study was supported by funds supplied from the general research support grant (NIH) to the University of Iowa College of Medicine. The author was a U. of I. faculty member during the course of the study. He is now in private practice in Darien, Connecticut, and is Director of Health of the Town of Darien.

A number of articles[4–10] on spina bifida refer to the occurrence of other malformations without presenting quantitative data. Kite[11] found 283 associated deformities among 1,447 cases of clubfoot. Shapiro *et al.*[12] found that of 604 malformed infants, 5% had more than one anomaly.

The present study was undertaken to provide further data on the incidence of various congenital malformations associated with myelomeningocele and on sex differences in such incidence.

## METHOD

A review was made of the records of all patients seen at the University of Iowa Hospital from 1938 through 1971 whose diagnoses fell in the H-ICDA listing of spina bifida and meningocele. The H-ICDA (hospital adaptation of the American adaptation of the International Classification of Disease) lists under the heading Spina Bifida and Meningocele the following diagnoses: fissure of spine, hydromeningocele (spinal), hydromyelia, hydromyelocele, meningocele (spinal), myelocele, myelocystocele, myelomeningocele, rachischisis, spina bifida (aperta), spinal hernia, syringomyelocele. Specifically excluded are meningocele (cranial) and spina bifida occulta. Nearly all the records studied were classified as myelomeningocele or spina bifida. There was a total of 434 patients, of whom 226 were males and 208 females. Many of these were included in Schwidde's study.

At least part of the variation in figures reported on the incidence of congenital malformations is due to differences in the definition of the term. In this study I have used the criterion proposed by Warkany and Kalter:[13] "We suggest that the term 'congenital malformations' be used for gross structural defects present at birth." Of course these defects may not be detected until months or years later.

Tabulations were made for each case of all congenital malformations in addition to myelomenin-

TABLE I

| Number of Concurrent Malformations | Number of Males | Percent of Males | Number of Females | Percent of Females |
|---|---|---|---|---|
| 0 | 47 | 20.8 | 28 | 13.5 |
| 1 | 58 | 25.7 | 50 | 24.0 |
| 2 | 41 | 18.1 | 53 | 25.5 |
| 3 | 38 | 16.8 | 26 | 12.5 |
| 4 | 14 | 6.2 | 24 | 11.5 |
| 5 | 18 | 8.0 | 15 | 7.2 |
| 6 | 5 | 2.2 | 7 | 3.4 |
| 7 | 3 | 1.3 | 3 | 1.4 |
| 8 | 1 | 0.4 | 2 | 1.0 |
| 9 | 0 | 0.0 | 0 | 0.0 |
| 10 | 0 | 0.0 | 0 | 0.0 |
| 11 | 1 | 0.4 | 0 | 0.0 |
| | 226 | | 208 | |
| Mean number of concurrent anomalies | 2.08 | | 2.33 | |

gocele reported in the physical examination. The records of many patients included several physical examinations, and all were consulted. Many patients had x-rays which demonstrated otherwise undetectable malformations. Autopsy reports were studied when available.

It should be apparent that the data derived from the study of these hospital records represent an underestimate of the associated malformations actually present. Some children were seen only once as outpatients and had no x-rays. Only a small number of autopsies was recorded, and many of the central nervous system malformations could be detected only at autopsy. The data are presented, then, with this qualification, which was also expressed by Ingraham and Swan.[2] It is clear, however, that no systematic bias was involved such as, for example, male records being more nearly complete than female.

## RESULTS

Table 1 presents the number of spina bifida patients with various numbers of associated congenital malformations. The average number of associated defects was 2.08 for males, 2.33 for females, and 2.20 for the entire group. The difference in the averages for the males and females is not statistically significant. There was a greater percentage of males who had no other congenital malformation, and this difference is close to statistical significance using the chi-square test ($p = .0529$).

Table 2 presents the number of male and female subjects in whom each of the listed congenital malformations was found. These are grouped according to the organ system or region involved. McIntosh *et al.*[1] comment on the difficulties of classification of congenital malformations, and remark that other investigators have noted these difficulties. Any classification is necessarily arbitrary. That on which Table 2 is based was found reasonably satisfactory for the purposes of this study.

Among the skeletal malformations, clubfoot (of all types) and dislocation of the hip were the most common. Lacunar skull is the third most frequent, and the difference in incidence between males and females is significant, $p < .05$. The sex difference in rib anomalies is also significant, $p < .005$. There is a marked sex difference in the total skeletal anomalies, with the greater incidence among females being highly significant, $p < .001$.

Hydrocephalus was by far the most frequent neurological defect recorded, and was the only one showing a significant sex difference, $p = .01$. The slight difference in total neurological malformations is not significant.

There are no significant sex differences among the individually listed facial malformations, but for the total number the preponderance of females is significant, $p < .005$. None of the sex differences in urinary tract anomalies or in the total thereof is significant when genital defects are excluded. When these latter are considered separately, a marked difference in incidence appears. Only 5 females had malformed genitalia, while 42 males were thus affected, a highly significant difference, $p < .001$.

The sex difference in the total number of cardiovascular malformations is significant, $p = .05$. As would be expected, the sex difference in inguinal hernia in the gastrointestinal category is significant, $p = .02$. None of the remaining individual or total sex differences is significant.

## DISCUSSION

This study bears out the belief that congenital malformations tend to be multiple. The average number of associated malformations was found to be 2.20, which is close to the average of 2.46 found by Ingraham and Swan and that of 2.17 found by Schwidde. When the spina bifida, which was the basis for each of the studies, is added to the associated malformations, the average total number of defects is 3.20 for the present study, 3.46 for

TABLE 2

*Skeletal*

| | Male | Female | Total |
|---|---|---|---|
| Clubfoot | 71 | 67 | 138 |
| Congenital dislocation of hip | 34 | 44 | 78 |
| Lacunar skull | 18 | 32 | 50 |
| Rib anomalies | 3 | 17 | 20 |
| Spinal anomalies | 3 | 10 | 13 |
| Defects of cranial bones other than lacunae | 4 | 7 | 11 |
| Scoliosis | 1 | 4 | 5 |
| Pilonidal sinus | 1 | 2 | 3 |
| Microcephaly | 1 | 2 | 3 |
| Bilateral dislocation of knees | 0 | 2 | 2 |
| Dolichocephaly | 0 | 2 | 2 |
| Flat feet | 1 | 1 | 2 |
| Brachycephaly | 0 | 1 | 1 |
| Cranioschisis | 0 | 1 | 1 |
| Craniosynostosis | 0 | 1 | 1 |
| Hemihypertrophy | 0 | 1 | 1 |
| Pectus excavatum | 1 | 0 | 1 |
| Absence of phalanx | 1 | 0 | 1 |
| Platybasia | 1 | 0 | 1 |
| Tibial torsion | 1 | 0 | 1 |
| Total | 141 | 194 | 335 |

*Facial*

| | Male | Female | Total |
|---|---|---|---|
| Strabismus | 17 | 20 | 37 |
| High palate | 3 | 7 | 10 |
| Low set ears | 1 | 6 | 7 |
| Cleft palate | 0 | 4 | 4 |
| Epicanthus | 0 | 3 | 3 |
| Micrognathia | 0 | 1 | 1 |
| Bifid uvula | 0 | 1 | 1 |
| Webbed neck | 0 | 1 | 1 |
| Short neck | 0 | 1 | 1 |
| Low hairline | 0 | 1 | 1 |
| Asymmetry of face | 1 | 0 | 1 |
| Cleft lip | 1 | 0 | 1 |
| Persistent anterior frenulum | 1 | 0 | 1 |
| Glossoptosis | 0 | 1 | 1 |
| Total | 24 | 46 | 70 |

*Cardiovascular*

| | Male | Female | Total |
|---|---|---|---|
| Hemangioma | 0 | 6 | 6 |
| Ventricular septal defect | 2 | 2 | 4 |
| Vascular malformation of CNS | 2 | 2 | 4 |
| Coarctation of aorta | 0 | 1 | 1 |
| Single umbilical artery | 0 | 1 | 1 |
| Atrial septal defect | 0 | 1 | 1 |
| Patent ductus arteriosus | 0 | 1 | 1 |
| Congenital heart disease, unspecified | 0 | 1 | 1 |
| Myocardial cushion defect | 1 | 0 | 1 |
| Ectopic right subclavian artery | 1 | 0 | 1 |
| Total | 6 | 15 | 21 |

*Genitalia*

| Male | | Female | |
|---|---|---|---|
| Undescended testes | 24 | Colonic vaginal fistula | 1 |
| Phimosis | 11 | Deformed genitalia | 1 |
| Hydrocele | 4 | Absence of vagina | 1 |
| Epispadias | 1 | Vestigial uterus | 1 |
| Hypospadias | 1 | Fusion of labia minora | 1 |
| Aplasia of testes | 1 | | |
| Total | 42 | | 5 |

*Neurological*

| | Male | Female | Total |
|---|---|---|---|
| Hydrocephalus | 121 | 137 | 258 |
| Cerebral malformations* | 66 | 44 | 110 |
| Hydromyelia | 5 | 4 | 9 |
| Diastematomyelia | 5 | 1 | 6 |
| Lipoma of spinal cord | 2 | 2 | 4 |
| Dysplasia of optic nerve | 2 | 0 | 2 |
| Cerebellar malformations | 2 | 0 | 2 |
| Diplomyelia | 0 | 1 | 1 |
| Blindness | 0 | 1 | 1 |
| Phrenic nerve palsy | 1 | 0 | 1 |
| Total | 204 | 190 | 394 |

* These included Arnold-Chiari deformity, atresia of aqueduct of Sylvius, agenesis of septum pellucidum, agenesis of corpus callosum, hypoplasia of corpus callosum, anencephaly, midbrain deformity, hydrobulbia, porencephaly, encephalocele, microgyria, deformed third ventricle.

*Urinary Tract Exclusive of Genitalia*

| | Male | Female | Total |
|---|---|---|---|
| Hydronephrosis† | 3 | 5 | 8 |
| Hydroureter | 3 | 4 | 7 |
| Horseshoe kidney | 4 | 3 | 7 |
| Malrotated kidney | 0 | 1 | 1 |
| Lobulated kidney | 0 | 1 | 1 |
| Ectopic kidney | 0 | 1 | 1 |
| Duplication of kidney | 0 | 1 | 1 |
| Exstrophy of bladder | 1 | 0 | 1 |
| Agenesis of kidney | 1 | 0 | 1 |
| Ureteral stricture | 1 | 0 | 1 |
| Atresia of ureteral orifice | 0 | 1 | 1 |
| Total | 13 | 17 | 30 |

† Hydronephrosis and hydroureter eventually develop in a large proportion of patients with myelomeningocele. The cases tabulated here had these conditions present at birth as determined by autopsy or pyelogram within the first few weeks of life.

*Gastrointestinal*

| | Male | Female | Total |
|---|---|---|---|
| Inguinal hernia | 12 | 2 | 14 |
| Umbilical hernia | 7 | 4 | 11 |
| Meckel's diverticulum | 3 | 2 | 5 |
| Malrotation of intestine | 0 | 4 | 4 |
| Omphalocele | 1 | 2 | 3 |
| Imperforate anus | 1 | 1 | 2 |
| Lobulation of liver | 0 | 1 | 1 |
| Exstrophy of bowel | 1 | 0 | 1 |
| Rectal prolapse | 1 | 0 | 1 |
| Total | 26 | 16 | 42 |

TABLE 2 *(Continued)*

| | Male | Female | Total |
|---|---|---|---|
| *Muscular* | | | |
| Absence of abdominal muscles | 1 | 1 | 2 |
| Absence of muscles below the knee | 0 | 1 | 1 |
| Diastasis recti | 0 | 1 | 1 |
| Arthrogryposis | 1 | 0 | 1 |
| Total | 2 | 3 | 5 |
| *Respiratory* | | | |
| Pulmonary hypoplasia | 1 | 0 | 1 |
| Tracheal polyp | 1 | 0 | 1 |
| Total | 2 | 0 | 2 |
| *Miscellaneous* | | | |
| Hamartoma | 1 | 0 | 1 |
| Hypoplasia of adrenal gland | 0 | 1 | 1 |
| Total | 1 | 1 | 2 |

that of Ingraham and Swan, and 3.17 for Schwidde's subjects.

McIntosh *et al.* found that 14.8% of their malformed infants had more than one malformation. Kite[11] found an associated deformity in 20% of 1,447 cases of clubfoot, with some having more than one deformity. In the present study 82.7% had one or more malformations in addition to their myelomeningocele. It is hard to account for this vast discrepancy. Perhaps whatever factors produce myelomeningocele are more likely to cause additional congenital malformations than is the case with causal factors of other defects, but this is a question-begging supposition. It is to be hoped that the considerable body of present research in teratology will eventually elucidate the problem.

The statistically significant sex differences are likewise puzzling. The greater incidence of skeletal anomalies among females is noteworthy, as is the similar situation with regard to malformations in the facial region and hydrocephalus, and the somewhat less significant difference in cardiovascular defects. The two congenital defects which affected significantly more males than females were those of the genitalia and inguinal hernia. There are no published data with which to compare these sex differences, since no previous investigation considered sex differences. Research on the explanation of these findings is needed.

## SUMMARY

A study was made of the hospital records of 434 patients with myelomeningocele to determine frequency and type of associated malformations and to discover any sex differences existing. Eighty-two and seven tenths per cent (82.7%) of the records listed at least one additional malformation. This figure is higher than corresponding figures in previously published reports. A greater percentage of males than of females had no associated defect. Significantly greater percentages of females had associated skeletal anomalies, facial malformations, hydrocephalus, and cardiovascular defects. Significantly greater percentages of males had inguinal hernias and malformed genitalia. Explanation of these differences is lacking.

## ACKNOWLEDGEMENT

The author wishes to thank Leon F. Burmeister, Ph.D., of the Department of Biostatistics, University of Iowa College of Medicine, for his generous help in the statistical analysis of the data in the study.

## REFERENCES

The references noted in this article may be obtained from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

## IOWA MEDICAL MISCELLANY

*(Continued from page 85)*

**PT ELEMENTS . . .** First draft of a document entitled "Essential Elements for Institutional Physical Therapy Services" has been provided to a joint committee of the IMS, Iowa Hospital Association and Iowa Physical Therapy Association.

**AUXILIARY . . .** IMS Board of Trustees has approved a recommendation to change name of the Woman's Auxiliary to the IMS to Iowa Medical Society Auxiliary. Final action will be taken April 30/May 1 at WA-IMS annual meeting.

**DONALD L. TAYLOR . . .** Executive Vice President, Iowa Medical Society, has been elected first vice-president (president-elect) of the Professional Convention Management Association. Mr. Taylor will be installed as president at annual meeting of PCMA in New Orleans in January 1976.

**WASHINGTON TREK . . .** Annual call by the Iowa medical profession on the state's congressional delegation in Washington, D. C., will take place in May. A representative of IMPAC and the IMS will discuss medical issues with Iowa's senators and representatives.

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**References: 1.** Muir, A., and Cossar, I.A.: Brit. Med. J. *2*:7-12 (July 2) 1955. **2.** Vickers, F.N.: Gastroint. Endosc. *14*:94-99 (Nov.) 1967. **3.** Roth, J.L.A.: Med. Clin. North Amer. *41*:1517-1537 (Nov.) 1957.

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# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## MARCH MEETINGS

March offers a changing picture in climate as well as personal endeavors. Winter comes to a blustering end and a hesitating spring is ushered in. Winds of a warmer temperature remind us of flowers, gardens, and vacations. Iowa physicians will have the opportunity to face a number of vistas with renewed vigor at five regional briefings offered in March by the Iowa Medical Society.

*Wednesday, March 12—Atlantic*
*Thursday, March 13—Spencer*
*Wednesday, March 19—Amana*
*Thursday, March 20—Waterloo*
*Wednesday, March 26—Des Moines*

Physicians are welcome to attend the meeting of their choice in order to gain further insight on the following subjects:

1. *The Medical Staff and the Hospital.*
2. *PSRO and the Iowa Foundation for Medical Care.*
3. *Professional Liability.*
4. *The American Medical Association.*
5. *IMS Legislative Program.*

A similar format of presentation will be used at each meeting. Society representatives with expertise in the several areas will present the current information and ample time will be denoted to questions and answers.

Note the places and dates; make your reservations. Be there.—M.E.A.

## RIGHT OR WRONG

The best bath for a newborn infant is no bath, according to a recent report by the Committee on the Fetus and Newborn of the American Academy of Pediatrics. The Committee recommended no cleansing of the newborn be done until the infant's temperature has been stabilized after delivery. Then the face and head should be rinsed with cotton soaked in sterile water or a mild non-medicated soap with careful rinsing with water. The rest of the skin should be left untouched unless grossly soiled, and the diaper area rinsed with sterile water and cotton or a mild non-medicated soap with water rinsing as required.

New reports have indicated the use of hexachlorophene when used as full-strength pHisohex® does cause brain damage in low-birth-weight infants. In a study of premature newborn infants, repeated whole body bathing with full-strength pHisohex was associated with disruption of the myelin of axons in the brainstem reticular formation. The researchers felt the high incidence in the smaller infants could be correlated with the fact that the more immature skin would absorb more hexachlorophene, and the more immature livers are less able to excrete the absorbed hexachlorophene.

It is concluded by the Committee report that hexachlorophene should not be used on small premature infants, and sparingly, followed by rinsing thoroughly with water, on larger infants.

This report, of course, brings us into the continuing problem of determining what is best care for our patients. Some of the things we do with apparent due consideration of serving best eventually develop into a harmful or deleterious result. The experiences with the thalidomide and chloramphenicol are bitter examples. The same

## EDITORIALS Continued . . .

type of controversy rages with regard to food additives, vitamins, iron, preservatives and coloring. Some advocate numerous additives for the nutritional good of all, while others rightfully plead that naturalness is the best. I am not arguing that either is right. I am sure that the organic-foods advocates have some good points, but that is not the whole answer. Those who argue against additives are also worthy of our attention. A recent report, for example, indicates that the ingestion of certain food colorings has an effect on certain children to make them "hyperactive." We cannot be total naturalists; some additives are necessary to the lives of some, but we do not need high doses (mega vitamins) of vitamin substances (natural or synthetic), or need to bathe our babies with deleterious substances. Yet, I hope we do not go so far with naturalness that we will expect mothers to lick their infants clean in the same manner that a cow cleanses her newborn calf. M.E.A.

## Morbidity Report for January, 1975

| Disease | Jan. 1975 | 1975 to Date | 1974 to Date | Most January Cases Reported From These Counties |
|---|---|---|---|---|
| Adenovirus | 1 | 1 | 6 | Polk |
| Amebiasis | 1 | 1 | | Jasper |
| Brucellosis | 1 | 1 | | Dubuque |
| Chickenpox | 1153 | 1153 | 733 | Black Hawk, Dubuque, Linn, Polk |
| Conjunctivitis | 123 | 123 | 27 | Decatur, Johnson, Polk, Warren |
| Encephalitis Viral | 1 | 1 | | Cerro Gordo |
| Assoc. with ECHO 4 | 1 | 1 | | Woodbury |
| Due to Herpes simplex | 1 | 1 | | Des Moines |
| Erythema infectiosum | 9 | 9 | 24 | Dubuque, Guthrie |
| Gastrointestinal viral inf. | 4515 | 4515 | 720 | Bremer, Buchanan, Chickasaw, Marion |
| Giardiasis | 2 | 2 | 2 | Des Moines |
| Hand, Foot & Mouth Disease | 1 | 1 | | Johnson |
| Hepatitis, A (Infectious) | 15 | 15 | 42 | Clinton, Palo Alto, Polk |
| Hepatitis, B (Serum) | 7 | 7 | 6 | Hamilton, Linn, Polk |
| Histoplasmosis | 3 | 3 | | Clarke, Mahaska, Polk |
| Impetigo | 65 | 65 | 17 | Greene, Linn, Marshall, Polk, Tama |
| Infectious Mononucleosis | 150 | 150 | 92 | Bremer, Johnson, Marion, Mills |
| Influenza-like illness | 11761 | 11761 | 1888 | Dallas, Howard, Marion, Polk, Van Buren |
| Influenza, lab confirmed | 70 | 70 | | Johnson, Linn, Polk |
| Meningitis *H. influenza* | 1 | 1 | 1 | Scott |
| Type unspecified | 5 | 5 | 4 | Mahaska, Muscatine, Poweshiek, Scott |
| Meningococcal Meningitis | 1 | 1 | 1 | Polk |
| Mumps | 75 | 75 | 295 | Guthrie, Muscatine, Polk, Webster |
| Parainfluenza type 3 | 6 | 6 | | Monona, Woodbury |
| Pediculosis | 42 | 42 | 33 | Benton, Black Hawk, Marion, Marshall |
| Pinworms | 3 | 3 | 17 | Johnson, Poweshiek, Scott |
| Pneumonia | 151 | 151 | 93 | Buena Vista, Jefferson, Johnson, Scott |
| Rabies in Animals | 7 | 7 | 8 | Scattered |
| Rheumatic fever | 2 | 2 | 5 | Cass, Scott |
| Ringworm, body | 26 | 26 | 35 | Scattered |
| Rubella | 1 | 1 | 2 | Story |
| Salmonellosis | 28 | 28 | 17 | Scattered |
| Scabies | 31 | 31 | 5 | Floyd, Johnson |
| Shigellosis | 7 | 7 | 11 | Black Hawk, Buchanan, Johnson, Louisa |
| Streptococcal infections | 1000 | 1000 | 923 | Dubuque, Jackson, Johnson, Marshall, Polk |
| Tuberculosis, number ill | 5 | 5 | | Scattered |
| Tuberculosis, sputum positive | 4 | 4 | | Scattered |
| Venereal Diseases: Gonorrhea | 126 | 126 | 536 | Black Hawk, Linn, Louisa, Polk, Scott |
| Syphilis | 5 | 5 | 53 | Cherokee, Pottawattamie, Story, Webster |

Laboratory Virus Diagnosis Without Specified Clinical Syndrome

| | | | | | |
|---|---|---|---|---|---|
| Coxsackie B2 | 1 | Coxsackie B5 | 1 | Herpes simplex | 9 |
| Coxsackie B3 | 1 | Cytomagalovirus | 4 | Herpes zoster | 3 |
| Coxsackie B4 | 1 | Eaton's agent | 5 | | |

# State Department of Health

## EMERGENCY MEDICAL SERVICE

Great progress has been made the last several years in improving the emergency medical services available to Iowans. This progress has been made in all aspects of emergency medical services. Hospital emergency medical capabilities have been categorized and many hospitals have upgraded their services. A coordinated communication system has been planned to facilitate ambulance access and to permit good communication between ambulance attendants, hospital personnel and physicians, law enforcement personnel and others. Many new ambulances have been purchased which are designed to provide in-transit care. Medical equipment necessary for the provision of care at an accident scene and en-route to a hospital has been purchased and is being used. Over 2500 ambulance attendants have completed the 81-hour Emergency Medical Technician-Ambulance (EMT-A) training course. This training has been supported by hundreds of Iowa physicians who have served as instructors and in other capacities.

Although this progress has been made, Iowans cannot yet be assured the service they receive when they call an ambulance will be of uniformly high quality or will even meet some minimum standards. In too many instances, the person needing an ambulance may find it difficult to determine, in the time of emergency, just what ambulance service serves them. They may find the ambulance that arrives is a vehicle with limited room in the patient area. They may find the ambulance carries little of the equipment recommended for the provision of emergency care and may find the ambulance attendants have had little or no training in emergency care. Because of these deficiencies some patients' injuries or illnesses may be more disabling than they might have been with prompt correct care. Moreover, a few patients who may die might be saved.

Legislation is needed. A number of legislators, the Governor's Emergency Medical Service Advisory Council, the Iowa State Department of Health and many other organizations and individuals feel legislation is needed to require minimum standards for ambulance service. Since physicians are likely to be asked questions regarding this, a review seems appropriate as to what the proposed legislation would and would not do.

Legislation in this area would require ambulance services to be licensed. Ambulances would be defined as vehicles used to transport patients. Vehicles presently called rescue units would not be considered as ambulances if they are used only to transport rescue tools and equipment, but would be considered as ambulances if they are used to transport patients. Those that are not ambulances would not be covered by the proposed legislation. The minimum standards for ambulance services would be established in rules developed with the guidance of the Emergency Medical Service Advisory Council. These standards would include: vehicle specifications, equipment requirements, attendant training, dispatching and communications, hours of operation and staffing and insurance requirements. Such minimum standards would not take effect on the effective date of the act, but would be phased in over several years.

Ambulance service is currently provided in Iowa through a variety of patterns. Many are volunteer ambulance services, or volunteer fire department ambulance services, others are hospital based ambulance services, private ambulance services, government operated services, etc. We would expect ambulance service to continue in all of these patterns under the proposed legislation. The only type of ambulance service

threatened by the legislation would be the one providing inadequate service. Once the law and regulations became operative, Iowans needing ambulance service would be assured of service meeting minimum standards. Lives would be saved and disability reduced.

## INFLUENZA 1974-75

The Iowa State Hygienic Laboratory has identified type A influenza virus infection from clinical specimens taken from persons ill in Iowa during the last two weeks of December, 1974. Influenza $A_2$ virus has been isolated by culture from seven persons and its infection documented serologically in another six persons. The infections have occurred in Iowa City, Dubuque, Guttenberg, Des Moines and Storm Lake.

Surveillance of absentee data from schools and selected industries in various parts of the State, as well as attendance figures in out-patient departments in Des Moines, have not yet shown evidence of large numbers of influenza cases occurring simultaneously. Interviews with physicians attending the specific cases indicate that the illness has been characterized by cough, chest pains, muscle aching, and "feeling very ill."

Although large-scale outbreaks, local or generalized, have not yet been reported to the State Department of Health, the presence of influenza virus in the State suggests that such events may occur within the next several weeks.

The State Department of Health advises that if recognized outbreaks of upper respiratory infection occur, clinical specimens should be obtained from representative patients for study at the State Hygienic Laboratory in Iowa City. Specimens appropriate to the diagnosis of influenza are acute throat swabs or washings, and acute and convalescent serum specimens. Advice and assistance in obtaining, preserving, processing and shipping specimens is available from the Infectious Disease Control Section of the State Department of Health and/or the State Hygienic Laboratory upon the reporting of such outbreaks.

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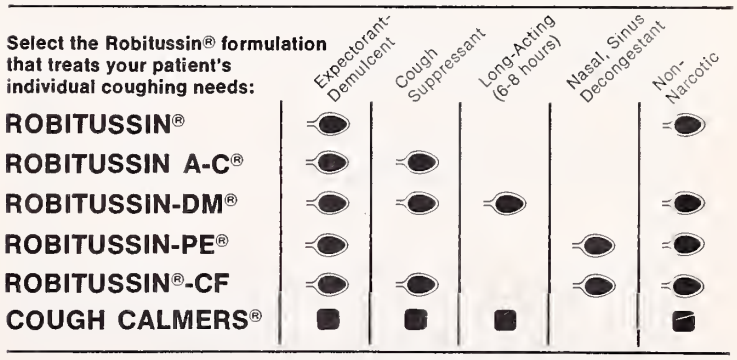


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# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## LEHREN/LERNEN

Which response best expresses the relation between teaching and learning?

a) They both happen in classrooms.

b) Teaching is performed by someone called a teacher; learning, by someone called a learner.

c) Teaching is one of the best methods for learning.

d) Teaching is active; learning is passive.

e) There is almost no relation between teaching and learning.

f) Teachers are usually older than learners and have more authority.

g) You can't get rich teaching, but you stand a chance if you learn well.

h) Everybody can learn; few can teach.

No matter which answer you prefer (except e), it's fairly clear that teaching and learning are somehow linked with each other. The German language (among others) adds an appealing linguistic likeness that has been lost in English: To teach/to learn = lehren/lernen. Yet, the English verbs share some subtle similarities—each has five letters, the first letter of each is tall, and the second and third letters of the two words are identical. The link between words and the ideas they express is not always just a historical fluke or random accident. (Such observations matter little, unless to titillate the latent etymologist that lies deeply buried in many of us.)

Let's compare thoughts on the quiz responses above:

a) Yes, teaching and learning happen in classrooms, but certainly everywhere else also. For active adults such as physicians, the bulk of their learning occurs *not* in classrooms.

b) Linguistically accurate, but fails to suggest the important interconnection between the two activities and those who do them.

c) Right on!

d) Teaching is usually active, but so is learning. Most people find that active learning is more fun and more lasting. Passive learning (if there be such a thing) is a little like eating grass—in one end and out the other without doing much for you.

e) Baloney!

f) Often true for childhood learners. Too often true for adult learners. Remember Cicero: "Nothing so inhibits learning as the authority of those who teach."

g) Largely correct (donations will be cheerfully accepted and acknowledged).

h) I'm not so certain about how many can teach (even among those paid to do so), but I've an extremely strong conviction that everybody can learn.

If you think differently about anything I've said, let me know. I'd enjoy learning from you.

Dr. Caplan is Associate Dean, Continuing Medical Education at The U. of I. College of Medicine.

## SPECIALTY BRIEFING

Twenty-three Iowa physicians representing 20 specialty organizations attended a briefing session presented by the Iowa Medical Society January 30 at IMS Headquarters. IMS President R. L. Wicks, M.D., moderated the program which included status reports on professional liability, hospital/medical staff relations, PSRO and the Iowa Foundation for Medical Care, state legislation and AMA activities.

# IMS SCIENTIFIC SESSION READY FOR LAUNCH

A broad spectrum of medical topics will be covered April 3-8 at the 1975 Iowa Medical Society Scientific Session. A delegation of approximately 125 persons will travel to Freeport, Grand Bahama, for this IMS continuing education event.

Society President R. L. Wicks, M.D., has praised the 1975 Program Committee for its outstanding efforts in selecting subjects and speakers. IMS Program Committee members are J. F. Murphy, M.D., Boone, chairman; R. W. Anderson, M.D., Des Moines; R. M. Caplan, M.D., Iowa City; W. B. Galbraith, M.D., Cedar Rapids; J. D. Kimball, M.D., Osceola; T. L. Place, M.D., Osage; G. W. Van Roekel, M.D., LeMars, and R. H. Westfall, M.D., Council Bluffs.

Topics on the agenda include:

Governmental Regulation of Pharmacotherapy, What's New in Immunology, The Poisons Around Us, New Drugs, Recognition & Evaluation of the Immune Deficient Patient, Drug Therapy & Workup in Hypertension, Dermatologic Problems, Management of Post-Radiation Problems, Hemorrhagic Shock, Cancer Therapy (Relations of Immunology & Oncology, Radiotherapy, Chemotherapy, Surgery), Psychiatry: Which Drug for What, Surgical Problems, Blood Component Transfusions, Severe Multiple Injuries, Cardiogenic Shock, Acute Respiratory Failure, Myocardial Infarction, Emotional Problems of Physicians & Spouses, Care of Poison Victims, Drug Dependence, Cancer of the Colon, Cardiopulmonary Resuscitation, Practical Hematology, and Care of Hodgkins Disease.

A "What's New In Medicine" session will include brief reports on anesthesiology, cardiology, surgery, psychiatry, toxicology, hematology, emergency medicine and medical education.

Speakers will include:

John Jennings, M.D., Assistant Commissioner for Medical Affairs, Food and Drug Administration; Joseph Stetler, President, Pharmaceutical Manufacturers Association; T. R. Tephly, M.D., Professor of Pharmacology, Director, Oakdale Toxicology Center, University of Iowa; W. B. Galbraith, M.D., Cedar Rapids; Joseph Bellanti, M.D., Georgetown University School of Medicine; John Adams, Ph.D., Vice President, Pharmaceutical Manufacturers Association; R. M. Caplan, M.D., Professor of Dermatology, Associate Dean for Continuing Medical Education, University of Iowa; H. B. Latourette, M.D., Professor of Radiology, University of Iowa; Cleveland Trimble, III, M.D., Denver, Colorado; John Hoak, M.D., Professor of Internal Medicine, University of Iowa; John Stehlin, M.D., Clinical Professor of Surgery, Baylor University; M. J. Martin, M.D., Head, Department of Psychiatry, Mayo Clinic; Robert Eliot, M.D., University of Nebraska College of Medicine, and R. L. Westerlund, M.D., Ames.

The Session has been approved for 11 hours of elective credit by the American Academy of Family Physicians.

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# Medical Assistants

by TENORA MEYER, CMA

## FEATHER YOUR NEST WITH KNOWLEDGE

The 1975 state convention for medical assistants will be April 11, 12, and 13 at Jumer's Castle Lodge, Spruce Hills Drive & Utica Ridge Road, Bettendorf, Iowa. The program is as follows:

### FRIDAY, APRIL 11

4:00- 8:00 P.M. Registration
6:00- 7:30 P.M. Executive Council Meeting
8:00- 9:00 P.M. Scott County Chapter "Wellkommen" Party
9:00- P.M. Open House Campaigning

### SATURDAY, APRIL 12

7:00-NOON Registration
7:00- 8:30 A.M. Continental Breakfast
7:30- 8:30 A.M. Mini Test (CMA)
8:30-10:00 A.M. House of Delegates
10:15-10:45 A.M. General Assembly
Invocation
Welcome—Roma Brown, President, Scott County Chapter; Kenneth H. McKay, M.D., President, Scott County Medical Society; Kathryn Kirschbaum, Mayor, Davenport; and William Glynn, Mayor, Bettendorf
President's Message—Joann James, President, AAMA, State of Iowa, Inc.
11:00-NOON Program by E. A. Motto, M.D.—"Parkinson's Disease"
EXHIBIT AREA OPEN
12:30- 1:15 P.M. Luncheon
1:15- 1:45 P.M. Style Show, Compliments of Scharff's
2:00- 2:30 P.M. Program . . . AAMA Representative
2:30- 3:00 P.M. Orientation of State Officers
EXHIBIT AREA OPEN
6:00- 7:00 P.M. Cocktail Hour
7:15 P.M. Banquet
Master of Ceremonies: James Koch, Executive Secretary, Scott County Medical Society
Installation of Officers: Jeanne Green, CMA-A, Installing Officer
Entertainment: German Pioneer singers

### SUNDAY, APRIL 13

7:30- 9:00 A.M. Continental Breakfast
7:30- 8:30 A.M. Mini Test Review
8:30- 9:30 A.M. Post Convention Board Meeting
9:45-11:00 A.M. Program: "Medico-Legal"—Panel Discussion—Physician-Lawyer-Insurance Representative
11:00-11:30 A.M. Program (to be announced)
11:45-12:30 P.M. Luncheon
Adjournment

The Convention Chairman is Alice Diehl with Helen Ceperly serving as Co-Chairman. The Program Chairman is Marcine Sanders with Jeanne Green serving as Program Co-Chairman.

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### DETACH AND RETURN REGISTRATION FORM WITH CHECK

| | | |
|---|---|---|
| Registration, Non-Members | $30 | (Meals and educational sessions) |
| Registration, Members | $25 | (Meals and educational sessions) |
| Educational Sessions only | $ 7 | (Students $3.50) |
| CMA Mini Test | $ 2 | |

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ADDRESS .....

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ADDRESS .....

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ALTERNATE . .

Return registration and check made payable to:
AAMA, Scott County Chapter Convention Fund
c/o Miss Mary Ann Jaros, Registration Chairman
Office of Richard L. Bondi, M.D.
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**LOCUM TENENS WANTED—Internist or Family Practice physician in Des Moines Clinic. Address your inquiry to No. 1502, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

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**GENERAL PRACTITIONER—Psychiatric Hospital. Liberal fringe benefits. Near recreation areas and State Capital. Beginning salary $27,287 to $31,806 depending on qualifications. Internship, U. S. citizen and licensure required. Equal opportunity employer. Contact Louis Jensen, M.D., VA Hospital, Knoxville, Iowa 50138.**

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## INDEX TO ADVERTISERS


Air Force Medical Placement ..... 114

Burroughs Wellcome ..... 93, 100B

Dain, Kalman & Quail ..... 106

Geigy Pharmaceuticals ..... 86A, B

Lilly, Eli, & Company ..... 81

McNeil Laboratories ..... 105

Medical Protective Company ..... 110

North Central Medical Conference ..... 96

Pharmaceutical Manufacturers Association ..... 90-91

Prouty Company ..... 113

Robins, A. H., & Co. ..... 110A, B, 111

Roche Laboratories ..... 82-83, 94-95, 119-120

Roerig, J. B., & Co. ..... 100D

Searle, G. D., & Co. ..... 100, 100A

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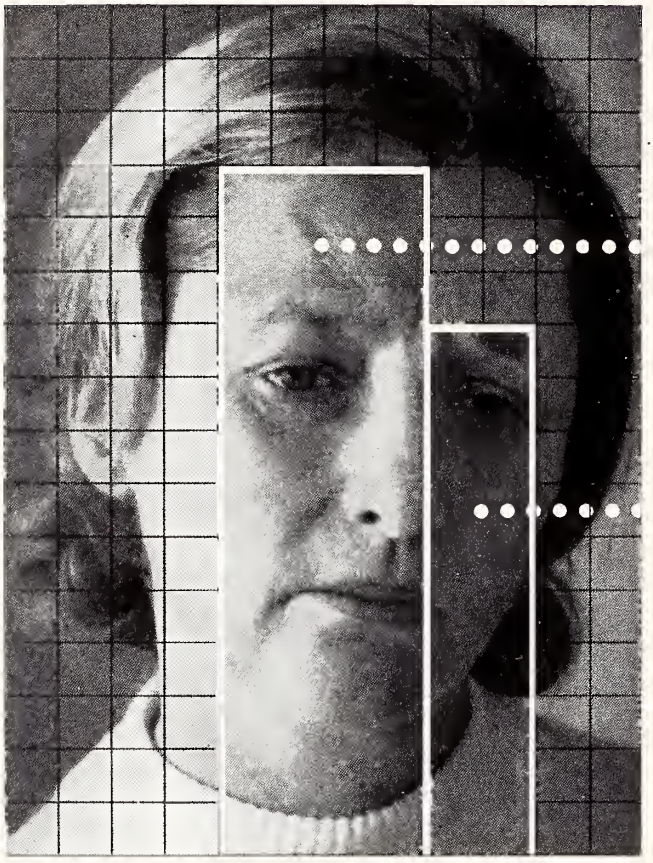
APRIL 1975

# Both often




**Before prescribing, please consult complete product information, a summary of which follows:**

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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures m require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous in gestion of alcohol and other CNS depres sants. Withdrawal symptoms (similar to those with barbiturates and alcohol) hav occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under careft

# respond to one

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n provide relief for both—as
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ved, the depressive symp-
ms associated with it are also
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There are other advan-
ges in using Valium for the
anagement of psychoneu-
tic anxiety with secondary
pressive symptoms: the
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alium is pronounced and
pid. This means that im-
ovement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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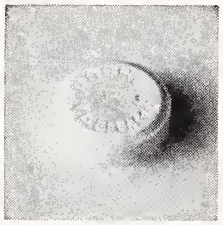

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in psychoneurotic
anxiety states
with associated
depressive symptoms

rveillance because of their predisposi-
n to habituation and dependence. In
egnancy, lactation or women of child-
aring age, weigh potential benefit
ainst possible hazard.

**ecautions:** If combined with other psy-
otropics or anticonvulsants, consider
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yed; drugs such as phenothiazines,
rcotics, barbiturates, MAO inhibitors
d other antidepressants may potentiate
action. Usual precautions indicated in
tients severely depressed, or with latent
pression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# President's Page

Several events and activities deserve special emphasis as we come down the "home stretch" of this Society year. All are important and worthy of reference at this time.

First, a word about IMPAC. The Iowa Medical Political Action Committee is now involved in a 1975 membership drive. The IMPAC quest for good government is a continuous one. Our search for and support of qualified candidates for governmental offices must be in constant process. Please join the 1975 IMPAC ranks and help the medical profession in its pursuit of good government.

Secondly, when this is read, the 1975 IMS Scientific Session will be history. This is yet another chapter in the Society's ongoing effort to provide varied educational and informational programming for interested member physicians. We hope those making this early spring (April 3-8) trip to the Bahamas will remember the experience with pleasure. My appreciation is extended to the 1975 Program Committee for its excellent work.

At the end of April, the IMS House of Delegates will assemble in Des Moines for a streamlined two-day session. A number of important matters are on the docket, e.g., professional liability, continuing medical education, PSRO, health planning, etc. My thanks in advance to those physician delegates who will represent their county societies in this policy-making endeavor.

Lastly, as this is the traditional University Issue of the JOURNAL, let me express best wishes to those academic colleagues who provide essential services. Dean Eckstein reviews the uncertain financial picture facing the College of Medicine in his comments. This is a further area of importance to the total profession.

Sincerely,

Ralph L. Wicks

*Ralph L. Wicks, President*

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# IOWA Medical Miscellany

**BUSY MONTH . . .** April opens with IMS Scientific Session (4/3-8) in the Bahamas with approximately 125 persons participating; program topics and speakers were noted in March JOURNAL. Annual meeting of IMS House of Delegates will be April 30/May 1 in Des Moines. Streamlined two-day House session will include consideration of reports and resolutions and election of 1975-76 Society officers.

**HANDBOOK MAILED . . .** Society activities for 1974-75 are highlighted in the Delegates HANDBOOK mailed in March to those IMS members who will represent their county societies at the Annual Meeting.

**SIX RESOLUTIONS . . .** From county societies appear in the 1975 HANDBOOK. These resolutions from Des Moines-Louisa, Clinton, Webster (2), and Dubuque (2) counties were received prior to the HANDBOOK deadline. Additional resolutions may be submitted for House consideration.

**CME RECOMMENDATIONS . . .** IMS Committee on Medical Education and Hospitals will ask 1975 House to approve a Continuing Medical Education Accreditation Program in which the Society would review and approve certain agencies and facilities which offer continuing education programs.

**MEDICAL REVIEW . . .** Recommendation of Committee on Medical Review regarding customary fee data has been endorsed by the Executive Council and referred to the House of Delegates. Two-pronged recommendation (1) limits distribution of customary fee data to Iowa Foundation for Medical Care which would continue to maintain "confidentiality" and assure "credibility," and (2) provides copy of Blue Shield's "Explanation of Benefits" to non-participating physicians as a means of assuring patient his Blue Shield claim is processed correctly.

**PROFESSIONAL LIABILITY . . .** Legislative activity in this area is continuing full scale. March IMS News Bulletin summarized six measures being offered to the Iowa General Assembly. Member physicians were urged to seek support of their legislators. Also in progress is Society evaluation of "captive agency" concept. Membership survey to determine carriers, extent of coverage, claims, etc., is in process and is part of the evaluation.

**PILOT PHARMACY PROJECT . . .** Being resubmitted to IMS House is a proposal of Blue Cross and the Iowa Pharmacy Service Corporation. Aim of project is to increase involvement of the pharmacist as an advisor to the physician on product selection, etc. Modifications have been made in earlier plan rejected by the House.

**MEASLES OUTBREAKS . . .** Rubeola outbreaks have been reported in several Iowa counties in 1975. State Department of Health and IMS Committee on Maternal and Child Health urge local physicians to assess the presence of rubeola and undertake appropriate immunization programs.

**MEDICAID IN '74 . . .** Iowa Medicaid paid out $58.3 million in 1974 with $6.1 million (10.5%) going to medical doctors; osteopathic physicians received just over $1 million. Percentage reimbursement to other sectors: inpatient hospital—18.4%; pharmacies—9.3%; intermediate care facilities—52.8%, and dentistry—4.2%.

**NEW PROGRAM . . .** A new continuing education activity instituted by the U. of I. College of Medicine is called "Primary Care Preceptorship Program for Faculty." Faculty participants will spend three days with practicing physicians in their communities, and, in turn, the local physicians will spend time with their faculty "preceptees" at the College of Medicine. Twelve faculty will participate this year.

*(Please turn to page 142)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 4
APRIL 1975

## TABLE OF CONTENTS

### UNIVERSITY ISSUE

Statement From John W. Eckstein, M.D., Dean, U. of I. College of Medicine . . 127
Financing Medical Education—1975
John W. Eckstein, M.D. . . . . 128
Everything's Up to Date in Iowa City
Mark Stephen Holcomb . . . . . 132
A Focus on the Iowa Medical Freshmen
Donald R. Bell . . . . . 137
Iowa's Physician Assistant Program—1975
Rex Montgomery, Ph.D., D.Sc., John J. Gerstbrein, R.P.A., and Denis R. Oliver, Ph.D. . . . . 139
Preceptorships in Primary Care: University of Iowa Experience
Richard M. Caplan, M.D. . . . . 143

### EDITORIALS

Annual University Issue . . . . . 150

### SPECIAL DEPARTMENTS

President's Page . . . . . 124
Iowa Medical Miscellany . . . . . 125
In the Public Interest
Seek Legislation to Ease Liability Dilemma . . . . . 153
State Department of Health
Morbidity Report . . . . . 155
About Iowa Physicians . . . . . 157
Deaths . . . . . 158

### MISCELLANEOUS

Appreciate the Service . . . . . 138
Thanks to Preceptors . . . . . 146
1973-74 Preceptors for Third Year Required Preceptorship . . . . . 147
1973-74 Preceptors for Fourth Year Elective Preceptorship . . . . . 147

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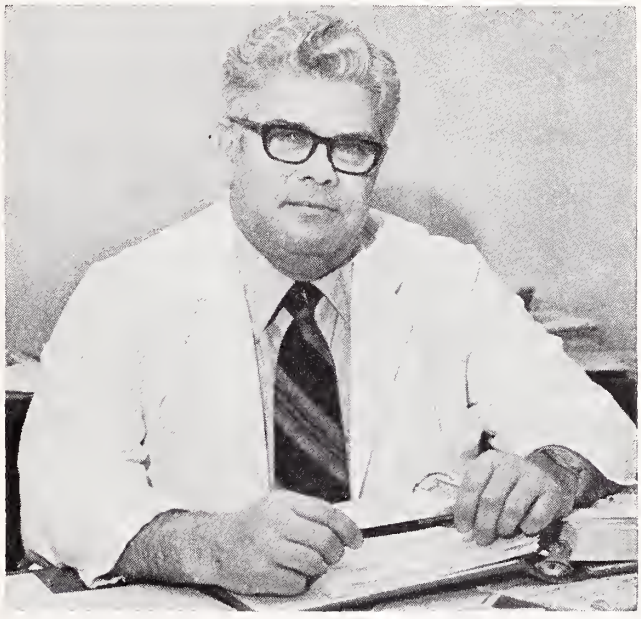
# UNIVERSITY ISSUE



Once again the editors of the JOURNAL have generously offered this space for use in communicating directly from this office to you. Since I see you in person all too infrequently, I am doubly grateful for this opportunity to speak of some of our major concerns in medical education.

This Spring I should like to share directly with you some of the current and continuing problems created by recent changes in thinking at the national level. If these frustrations were mine alone, I would not burden you with them; however, several members of the Society who know the problems have urged me to explain them to you, noting that they affect medical education generally and thus will ultimately have great effect on graduates of medicine throughout this country. Thank you, in advance, for whatever attention you can devote to the vexing problems described on the succeeding several pages.—JOHN W. ECKSTEIN, M.D., *Dean, College of Medicine*

# Financing Medical Education—1975

*A federal financial crunch is threatening much of the recent and important progress in medical and other health education activity in Iowa and elsewhere. Concerted efforts to increase manpower are now in jeopardy. This discussion outlines the specific impact on the College of Medicine.*

JOHN W. ECKSTEIN, M.D.
Iowa City

Medical educators have had to add a new term to their vocabularies this past year, and, unlike much of our beloved jargon, this one is pretty much self-explanatory: Federal Fund Losses.

Used in reference to the partial or complete withdrawal of federal support for various educational, research and facilities improvement construction programs, the term identifies one of the most serious problems now facing health science faculties. Because this is a fairly recent development which should be understood by everyone concerned about health care and about the public policies affecting the future providers of health care, it warrants discussion on these pages.

Federal dollars began to be available in some quantity in the early 1960's for education in medicine and the other health sciences, reflecting Congressional and Administration perception of vast unmet needs for health practitioners, especially in the less-populated areas of the nation. At The University of Iowa, plans were developed for the systematic enlargement of Medicine by 46% over the next decade, going in stages from 120 to 175 graduates each year by 1976. Similar growth was planned for the various resident training programs, for the allied health programs, and for the other U. of I. health colleges: Dentistry, Nursing and Pharmacy, whose students receive their basic science instruction in the College of Medicine.

## FEDERAL DOLLARS AT WORK FOR EDUCATION

Faculties were enlarged, new classroom-laboratory-office-library facilities were built, and more students were accepted, with federal funds underwriting much of the cost. These funds were by no means showered mindlessly upon the University; rather, they came to the campus earmarked for educational efforts, research, student aid and capital projects proposed by faculty members and selected for support by peer groups whose members understood the value of the proposed projects. Here it must be noted that College of Medicine faculty members have had an outstanding record of enterprise and success in attracting such support, which tends to flow toward individuals and institutions already recognized for quality performance.

During this time the State of Iowa also increased its support of higher education considerably, but for the most part it was the federal dollars which made it possible to acquire high quality faculty members in a highly competitive market, and to create some superb instructional facilities. Since requests for state legislative appropriations were reduced by the amounts which the health colleges anticipated receiving from federal sources, the proportion of state support for the College of Medicine dropped from 43% in 1962 to 30% 10 years later. This year Medicine receives just 26% of its support from state funds comprising legislative appropriations, tuition, and reimbursement for the University's overhead costs on grants.

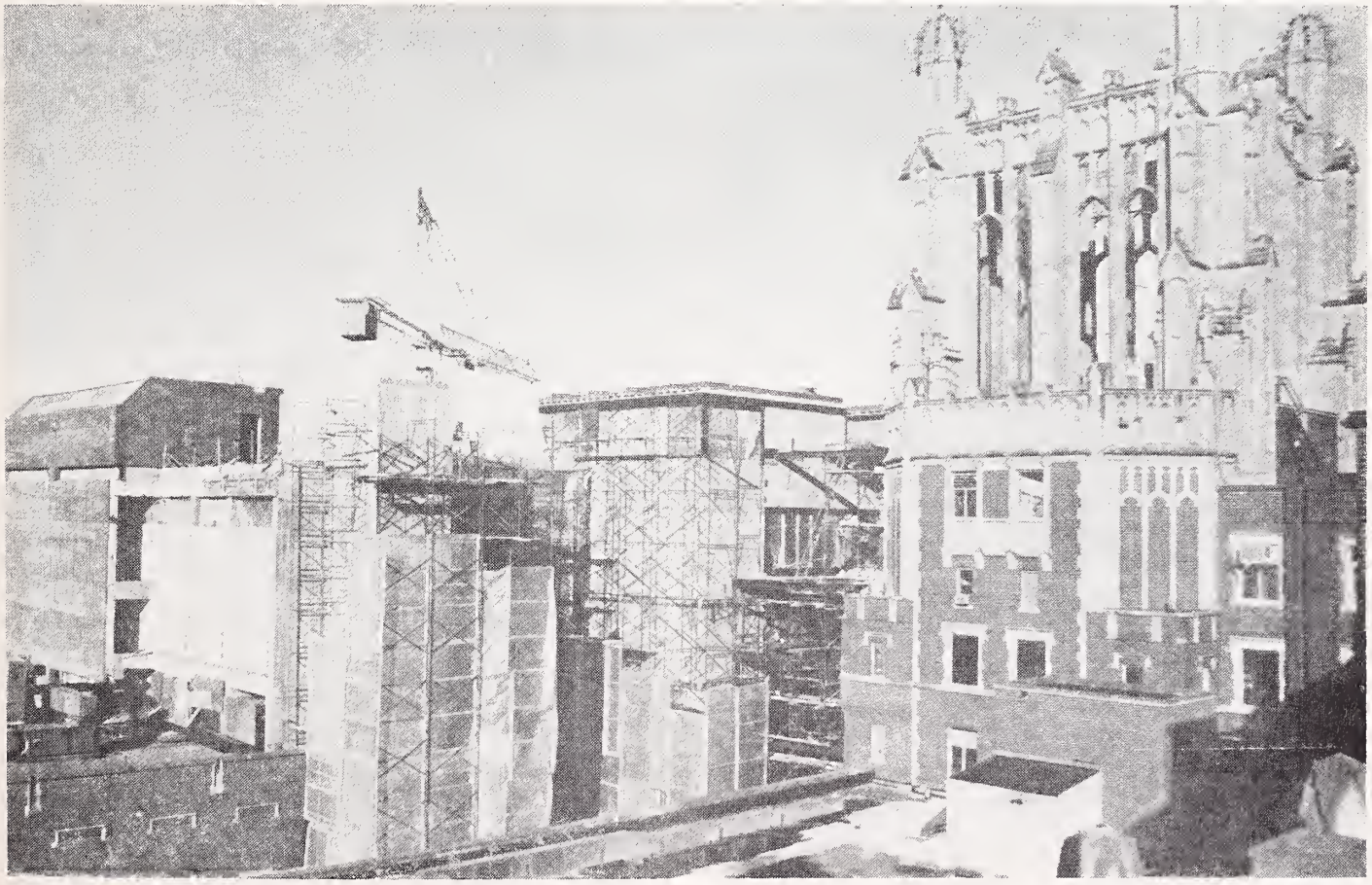
In considering the question of federal losses,

we are speaking here of the loss of direct support for *educational* programs, not research (for which funds have been available to health science schools for nearly 30 years), or construction (funded by various federal programs these past dozen years). Operating funds for education programs became available only in the last eight years from federal sources. These came in the form of basic improvement grants, special improvement grants, special project grants, training grants and capitation grants—specified numbers of dollars "per head" for support of each student enrolled.

Because an ongoing and productive health science educational facility such as The University of Iowa College of Medicine is perceived as a truly national resource, the various federal agencies—Health, Education and Welfare; National Science Foundation; Veterans Administration; Atomic Energy Commission; National Aeronautics and Space Administration—granted these funds with the understanding that there would be a long-term, continuing commitment to meet a known need for greater numbers of highly qualified personnel. Capitation and various capital grants were made with specific agreement that the College would increase its enrollment to a given size, would maintain that enrollment, and would continue to improve the quality of its instruction.

To support educational efforts in the U. of I. College of Medicine, these federal programs provided $6,062,494 in 1972-73, the peak year for such assistance. These funds stretched the state dollar supply to make possible high quality programs and to permit tuition to remain at levels generally appropriate for a public institution. They also stimulated the Iowa economy, and returned a significant number of federal tax dollars to the State of Iowa.

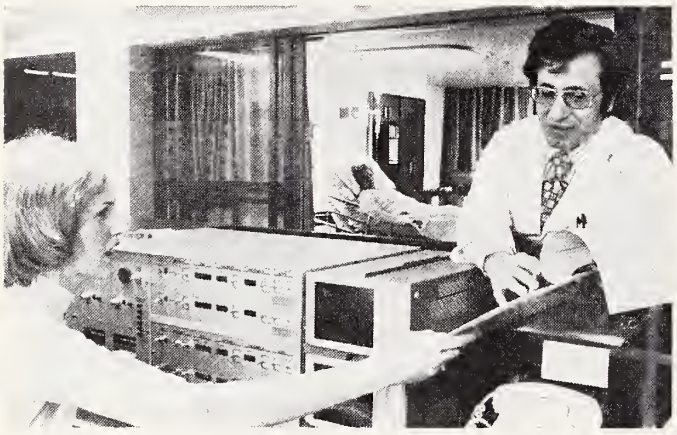
Two years ago the federal government began to back away from its previous commitment to these programs. In part, this represents a policy aimed at shifting the major burden for education back to the states. But it also reflects several



ON THE HORIZON—The North Tower Addition to University Hospitals is now approximately 60% complete and will be ready for occupancy in December. The seven-story addition will provide 168,000 square feet in which to house Internal Medicine, Surgery, Dermatology and Obstetrics and Gynecology Clinics. Twelve new operating rooms, as well as inhalation therapy and expanded radiology services, will be located in the North Tower Addition.

points of view recently expressed in some Congressional and Administration circles: that government spending must be generally reduced; that the nation is on the verge of having an adequate supply of physicians and other health professionals; that present educational and immigration programs will lead to surpluses; and that their earning potential is so great that medical students should be expected to pay for their own education.

It is left for the reader to judge how well these perceptions square with reality—especially considering that many of the officials expressing these beliefs also anticipate the advent of national health insurance, which will obviously lead to greatly increased utilization of medical personnel.



NEW CARDIAC SUITE—F. M. Abboud, M.D., Professor of Internal Medicine, reviews a patient's chart with Gayle Baumgartel, R.N., at one of the central nursing station monitors of University Hospitals' new 45-bed Cardiac Inpatient Suite.

Whatever the realities of manpower supply or educational financing, it is a fact that, as of this writing, the College of Medicine is scheduled to lose $1,605,000 for certain in 1974-76, with the strong possibility of losing still another $436,000. Not included in these figures, or in those presented during the past year to Regents and legislators, is the portion of salary support received from research grants, now fewer and harder to get. Salary funds provided from research grants have made it possible for the College to attract and hold many highly productive teachers and researchers who have contributed a great deal to the present-day quality of medical instruction.

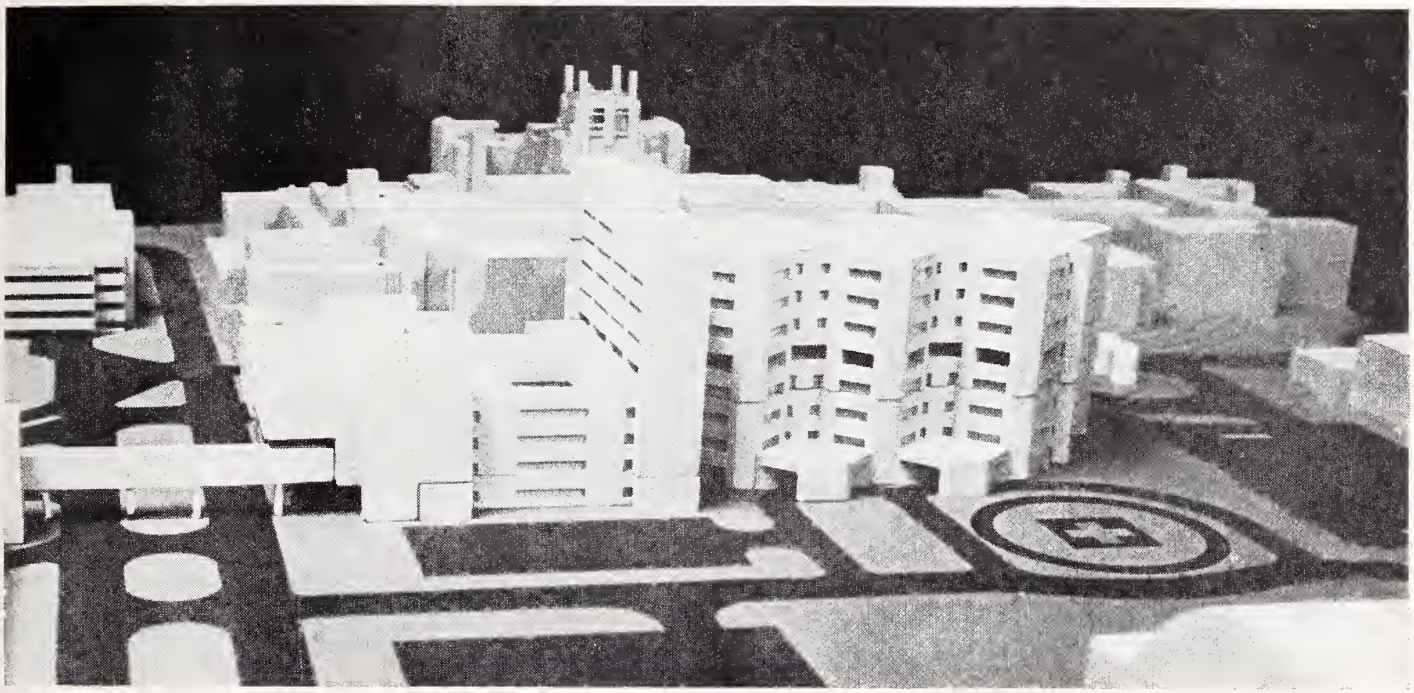
With federal support for research severely threatened, withdrawal of direct support for educational programs will further aggravate existing deficits in the numbers of faculty members in relation to the demands for teaching and patient care. At this point the College of Medicine anticipates a loss equivalent to about 9% of its payroll support for 1975-76, which would leave the College unable to fill vacant positions as they occur, or to keep up with spiraling costs unless this loss can somehow be replaced.

Iowa's problems in financing medical education are mirrored nationally, for the same reasons: nearly all schools have increased enrollments and added new programs in recent years, largely under the stimulus of health manpower legislation, and new schools have been formed. With competition increasing dramatically for top-quality teachers and researchers even as the programs to support their training continue to decline, the outlook for future staffing is tenuous, at best.

### STATE FUNDS: ONE-FOURTH OF COLLEGE BUDGET

In affecting the potential for volume of patient care, the federal fund withdrawal puts yet another squeeze on the College's ability to help itself, since $9 million—29%—of the current $31 million College of Medicine budget is derived from fees earned by faculty members for patient services rendered in University Hospitals and Clinics. As noted above, 26% ($8 million) of the current College budget is derived from the University's General Fund, with only $5.6 million of this sum representing tax appropriations (the rest being derived from tuition and indirect overhead income). The remaining 44% of the budget ($14 million) comes from federal funds.

If pro-rated among only the 1,075 full-time medical and postgraduate medical students enrolled this year in the U. of I. College of Medicine, that $5.6 million state appropriation would figure out to $5,298 per student. However, College of Medicine faculty members are also charged with teaching the basic sciences to students of the U. of I. Colleges of Dentistry, Nursing and Pharmacy, to large numbers of students in a score of other health science programs, and to still larger numbers of liberal arts students who take coursework in the basic sciences. In all, several thousand students are enrolled at any one time for instruction by College of Medicine faculty, whose clinical members are also responsible simultaneously for providing some $4 million worth of medical care (without charge) to



MAJOR EXPANSION—Groundbreaking for the Roy J. Carver Pavilion is scheduled for August and projected for completion in the Fall of 1977. It will provide facilities for a Family Practice Clinic and offices, an Orthopaedic Clinic and physicians' offices, and a Physical Therapy area. The Pavilion will also include a Trauma and Emergency Treatment Center and 96 inpatient beds to replace those now located in Children's Hospital.

indigent Iowans and individuals from correctional institutions.

(It may be of interest to note that the Governor's Budget recommends a state grant for the private College of Osteopathic Medicine and Surgery equal to approximately $8,000 per student who graduated from an Iowa high school or who lived one year in Iowa before enrolling at COMS. The College itself is seeking an appropriation to provide operating support at a rate equal to about $9,000 for each such osteopathic student.)

### SOME REPLACEMENT OF LOST FUNDS

The Regents, Governor Ray and the General Assembly have all shown concern for the disappearing federal dollar, and—more important!—they have taken positive action to replace some of the money lost from this source. The last legislative session appropriated $3 million for the Regents to utilize for this purpose among the three state universities in 1974-75, and $574,092 of this has already been "drawn down" by the College of Medicine.

There is much worse to come, however, with Medicine expecting to lose $1,500,300 in federal support for its educational programs in the next year (1975-76) plus an additional potential loss of nearly $1 million estimated for 1976-77.

College of Medicine and University of Iowa personnel are doing their best to explain the problem to state and federal lawmakers and administrators. Governor Ray has already recommended a state appropriation of $3 million to be shared among whatever Iowa programs from which federal support may be withdrawn in 1975-77. And in an effort to continue current progress and stave off future problems, special briefing sessions have been held with members of the Iowa Congressional delegation, in which we have urged that future health manpower legislation be supportive, not destructive, of our efforts to provide more and better educated physicians where they are most needed. Problems created by the federal pullback were explained in detail to several special assistants to the Secretary of the U. S. Treasury, invited to Iowa last month for that specific purpose by Governor Ray.

In particular, we have counseled continuation of some form of capitation support, and we have urged that the cost burden not be increased for either student or state. Finally, we have emphasized the need for a consistent national policy which will recognize that there must be a continued partnership among federal and state governments and the schools themselves in generating adequate support for medical education.

# Everything's Up to Date in Iowa City

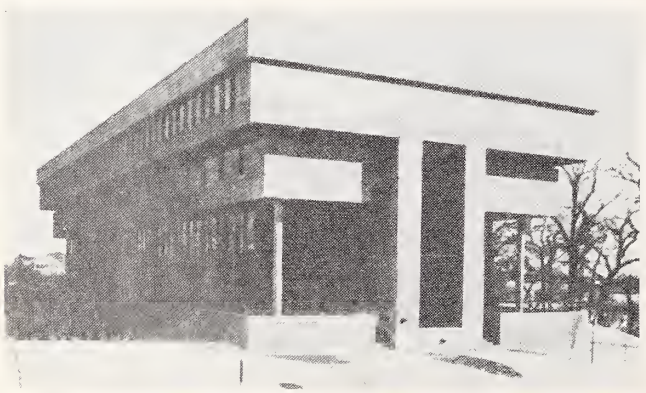
*University Hospitals and the College of Medicine—circa 1975—receive a light-hearted yet perceptive appraisal from a senior medical student. Viva new buildings. Viva new programs. But, as for excellence, "We try," he concludes.*

MARK STEPHEN HOLCOMB
Iowa City

IF YOU ARE an Iowa alumnus and have not been in Iowa City you had best pick up a map before your next visit. Things have changed. The University Hospitals and the College of Medicine have undergone a real face lifting. And the transfiguration is more than skin deep. Not only an impressive array of new buildings, but also a profusion of new programs, new departments and new people are on the scene.

Complexity complicated by confusion and congestion await the innocent newcomer to University Hospitals. Although the VA and the Tower hospital still gaze across the street at one another, the view has been cluttered by a collection of

Mr. Holcomb is a senior medical student at The University of Iowa College of Medicine. He is a current editor of VITAL SIGNS, the medical student publication. His home is Des Moines. The photographs were taken by Kim Brandt, a senior medical student. The illustrations are by Steven Vermillion, also a senior medical student.



Nursing Building—Said to resemble a glass bedpan.

Basic Science Building—Also called the Bastille.

Dental Building—Known by some as the Third Molar.

concrete mushrooms, aluminium extensions, and swarms of construction towers and walkways.

It began when the care, delivery and education of the health sciences became a *West Side Story.* Dentistry and nursing moved across the river to join medicine and pharmacy. Their new buildings rest on the west and east sides, respectively, of University Hospitals. Both structures are modern concrete and tinted glass affairs of unique architectural style. The Dental Building is fondly referred to as the Third Molar and the Nursing Building is said to resemble a glass bedpan.

Not to be outdone by the Joneses, University Hospitals began its own additions. In an apparent attempt to erect an outer defensive perimeter a new parking ramp was added on the west side, the Health Sciences Library was placed across the street to the north, and perhaps as a buffer against the Nursing Building, the Basic Science Building was placed on the east. Of the three, the parking ramp was probably the biggest success. At least with it there is a fair chance of getting in and out. The Basic Science Building, on the other hand, doubles as a human maze. The Bastille, as it is called, has an estimated 16½ miles of corridors and hallways. Standard equipment for the BSB is a ball of string, a package of bread crumbs, three candles, and a paperback, now in its sixth edition, called *Braving the Basic Science Building.* Even more amazing than the BSB is the HSL (Health Sciences Library). Located equi-inconveniently from the nursing, dental and medical schools, it is best described as Picasso's interpretation of the Ginger Bread House. At night it takes on all the quiet warmth of a concrete castle.

The VA, caught up in the excitement, decided to install air conditioning. This project, for rea-

North Tower Project—Going, Going, Gone Is the University Hospitals' Tower.

"Matchmaker, Matchmaker. . . ."—The seniors' theme song as the National Intern and Resident Matching Program performs its function.

sons not clear to the casual observer, soon took on the complexity of the Aswan Dam.

It should be noted in passing that the Dean's Office, like the Vatican, became an autonomous entity when it moved into temporary residence on the north side of the Medical Research Center. It seems appropriate that this aluminium pseudopod most closely resembles the temporary quonset huts of the 1940's still being used on the campus.

Finally, as a *coup de grace* to the old and the familiar, the North Tower Project was launched. When completed the University Hospitals' Tower will have unfortunately vanished behind the new addition, but the project will afford many patients the opportunity to study a brick wall at their leisure by simply drawing a curtain.

## NEW SET OF WRINKLES

As one becomes familiar with the University, the initial impression of confusion becomes a conviction. Which is as it should be. Any institution that annually turns out four million pounds of laundry and a medical school class must be a big time operation. Although the laundry situation has been simplified by permanent press sheets, a whole new set of wrinkles has been introduced into medical education by programmed learning, physician's assistants, family practice, professional patients, the integrated internship, an elective senior year and student instructors.

Programmed learning supplies sequences of information in building block units. Its strength is that the student must perceive before he can proceed. Its weakness is that after 16,000 responses programmed learning becomes *A) boring, B) monotonous, and C) both A and B.*

The Physician's Assistant Program is Iowa's answer to the paramedics. The PA, intended as an intermediate member of the health care team, spends time in the classroom and on the ward with the medical students in preparation for his career.

The Family Practice Department provided a viable alternative to the Iowa legislature's clamor for primary medical care in the State. In fact, the new residency became temporarily so popular that to reveal an interest in another specialty was worse than sneezing into the incision during surgery.

*(Please turn to page 136)*

CLASS SIZES—1975

| *Class* | *Number* |
|---|---|
| Freshman | 175 |
| Sophomore | 176 |
| Junior | 152 |
| Senior | 147 |

## MEDICAL CURRICULUM

### First Year—Semester 1

| *Course Title* | *Sem. Hrs.* |
|---|---|
| Gross Human Anatomy | 8 |
| Microscopic Anatomy | 4 |
| Biochemistry | 6 |
| Perspectives in Medicine | 1 |
| | 19 |

### First Year—Semester 2

| | |
|---|---|
| Microbiology | 7 |
| Medical Physiology | 6 |
| General Pathology | 5 |
| Endocrinology | 2 |
| Basic Skills in Emergency Medicine (Optional) | |
| | 20 |

### Second Year—Semester 1

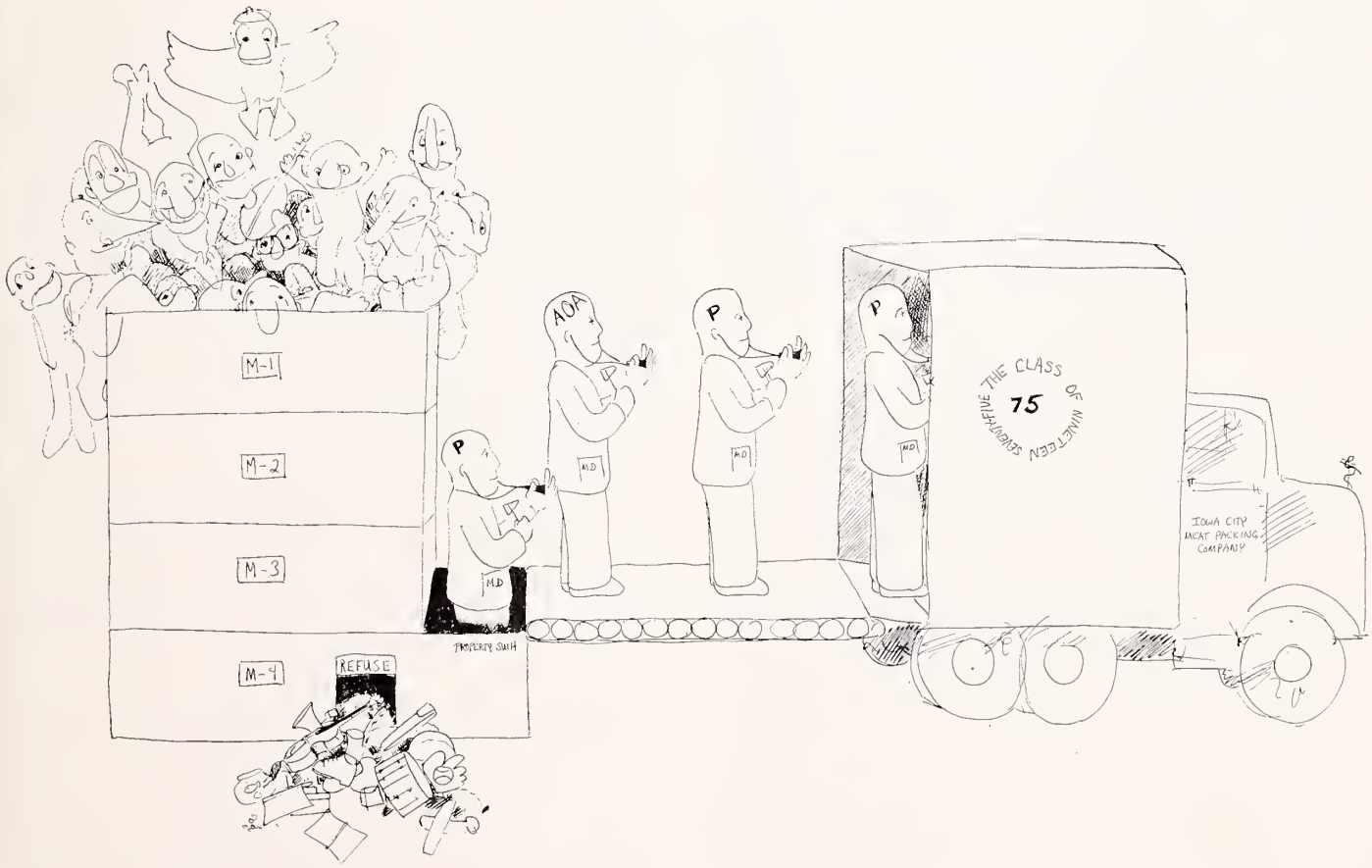
| | |
|---|---|
| Systemic Pathology | 7 |
| Pharmacology | 5 |
| Neurobiology & Basic Science of Behavior | 5 |
| Community Health | 2 |
| | 19 |

### Second Year—Semester 2

| *Course Title* | *Sem. Hrs.* |
|---|---|
| Introduction to Clinical Medicine | 20 |

### Third Year

| | |
|---|---|
| Medicine | 9 |
| Surgery | 6 |
| Obstetrics & Gynecology | 6 |
| Pediatrics | 6 |
| Psychiatry | 6 |
| Neurology | 2 |
| Otolaryngology | 2 |
| Orthopaedics | 2 |
| Urology | 2 |
| Dermatology | 2 |
| Anesthesiology | 2 |
| Preceptorship | 2 |
| | 47 |




The medical mill grinds slowly but graduates it does produce.

The medical student is the recipient of tender and loving instruction from the ubiquitous faculty.

Professional patients were conceived, appropriately, by the Ob-Gyn Department to lick the difficult task of mastering the pelvic exam. These people have provided excellent technical assistance to the department and have recently become involved in tuning up medical students' communication skills.

### END OF INTERNSHIP

The year 1975 is noteworthy because it marks the end of the internship. From now on the intern will be known as a first year resident. Actually his job will still be an intern's, but his title will be resident. And he must be a resident in something: surgery, internal medicine, orthopedics, neurology, whatever. Consequently, the senior medical student must know not only where he wants to go but also what he wants to be before he interviews. The end result is that a tentative decision on a specialty area must be reached before the end of the junior year. Neither students nor staff like the situation but both find themselves attempting to accommodate to it. For every senior the wait until the computer matching results are posted is uniquely suited to growing an ulcer on a steady diet of fingernails.

Fortunately, the senior year is the antithesis of the inflexibility encountered after graduation. The fourth year is entirely elective with the thought that since the first three supposedly supplied the cake, the fourth should supply the frosting. Although only eight months of credit are required, most seniors feel they need at least 18 to gather the minimum goodies for their gray matter before graduation.

One of the recent twists on *see one-do one-teach one* involves students teaching students. Senior students are taking an active role in teaching second semester sophomores how to examine a patient and take a physical. It is safe to say that the seniors, at least, are learning how to do a damn good work-up.

More buildings, more equipment, more students, more staff. Certainly bigger. And better? No simple answer is possible. Ultimately it rests with each patient who comes through our door seeking help. I like to think the preferred answer is, as it has always been, we try.

# A Focus on the Iowa Medical Freshmen

*9.3% of the 1974 medical freshmen are Iowans—from 66 different counties. The 175 freshmen are 16% female and 30% married. 85% were undergraduate science majors and active in campus endeavors. 12.5% have fathers who are physicians.*

DONALD R. BELL
Iowa City

The College of Medicine recently greeted its 105th freshman class, whose 175 members present the strongest academic credentials in the history of the College. These students were selected from among the 629 candidates who were allowed to file complete application materials and were given full consideration by the admissions committee. Almost 1,500 applicants submitted preliminary applications.

As has been true for several years, residents of the State of Iowa comprise the overwhelming majority of the new class—93%, drawn from 66 of Iowa's 99 counties. On the other hand, 25% of the class members did their undergraduate work outside Iowa, with 19 states from Massachusetts to California being represented.

The 28 women matriculating in the 1974 class represented 16% of the total—about the same percentage of women that existed in the applicant pool. Seven members of minority groups (six Afro-Americans, one American Indian) are enrolled under the Educational Opportunity Program. While fewer than 30% of the new class members are married, statistics on previous classes would suggest that about two-thirds of the class will be married by the time its members graduate in 1978.

Mr. Bell is Coordinator of Admissions and Records at The University of Iowa College of Medicine.

This year continues the trend toward greater representation of students who have completed three years of college as opposed to students already possessing a baccalaureate degree. About 25% of the 1974 entering class can be classified as third-year applicants. The strong emphasis toward undergraduate majors in the sciences also continues in this class, with more than 85% of those enrolled having majored in an undergraduate science-related area (38% in biological sciences, 13% in chemistry, 2% in physics or math, 33% in pre-medicine/general science). Eight per cent of the enrolled freshmen majored in a humanities or social sciences area.

Undergraduate academic achievement is an important factor in the medical school selection process. This year's freshman class presents very strong academic credentials, with the mean science scores and over-all grade points averaging about 3.60. Ninety-five per cent of the class presented undergraduate science GPA's higher than 3.1 and over-all GPA's higher than 3.2.

Performance on the Medical College Admission Test is another important variable in freshmen selection. Here is the mean level achieved on each subtest by members of the 1974 entering class:

| Test | Iowa Freshman Mean | National Percentile Rank |
|---|---|---|
| Verbal ability | 539 | 60 |
| General information | 548 | 68 |
| Quant ability | 626 | 71 |
| Science | 615 | 77 |

Apart from their academic credentials, those enrolling were generally active in extracurricular campus life, with almost 60% of the class reporting that they participated in two or more organized extracurricular clubs, activities or committees during their last year in college. In addition, 30% held or ran for elective class or campus office while in college.

The incoming freshmen reflect a wide variance

in the size of community they lived in longest. Seventeen per cent come from the country or from towns of less than 1,000 population, and 45% come from cities of less than 10,000. At the other end of the scale, 20% of the class come from cities of 100,000 or more.

Long standing trends concerning the occupational backgrounds of parents of enrolled freshmen appear again in this year's class. About 60% of the incoming freshmen have fathers who are in the business and professional occupations. Within this group, 34 (19%) of the students' fathers are engaged in health-related careers (22 or 12.5% of the fathers are physicians). Most of the mothers of the freshmen list themselves as housewives (54%). Of those who are pursuing careers, about half are engaged in clerical and sales-related positions.

The educational level of the parents of this year's freshmen continues another stable pattern, with about 30% of the fathers having earned an advanced graduate or professional degree and 46% having at least a bachelor's degree. Seven per cent of the mothers have advanced degrees, while one-third of them hold a bachelor's degree.

The freshman class of 1974 looks very similar to the classes admitted in the previous three years on the basis of these factors. It presents an over-all picture of high academic and intellectual ability, and of diversity of background as reflected in size of home community.

## APPRECIATE THE SERVICE

Medical education is greatly aided by input from Iowa practitioners across the state. To the 13 Iowa physicians who currently serve on its various committees, The University of Iowa College of Medicine wishes to express its gratitude.

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*COMMITTEE ON CANCER*

R. E. Weland, M.D., Cedar Rapids

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W. H. Verduyn, M.D., Reinbeck
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# Iowa's Physician's Assistant Program—1975

REX MONTGOMERY, Ph.D., D.Sc.
JOHN J. GERSTBREIN, R.P.A., and
DENIS R. OLIVER, Ph.D.
Iowa City

*Full accreditation of the Iowa Physician's Assistant Program has been achieved in recent weeks. The first class of 10 PA's completed its two-year course of study last fall, seven are now working in Iowa, five in towns under 10,000 population. Eighteen additional PA's will graduate this fall.*

The Physician's Assistant Program at The University of Iowa was commenced in September, 1972, following a detailed analysis of the PA concept by constituents representing many segments of the health care delivery system. An act to establish a program to permit physician's assistants to work under a physician's supervision was approved in April, 1971, by the Iowa General Assembly. This had been preceded in 1970 by a state-wide survey of physicians, conducted by John C. MacQueen, M.D., of the College of Medicine faculty, to obtain their opinions and ideas concerning physician's assistants. The survey was followed in the fall of 1971 by the appointment of an *ad hoc* committee of the faculty, chaired by D. L. Dunphy, M.D., and charged by Dean John W. Eckstein, M.D., to review the feasibility and the desirability of the development of a Physician's Assistant Program at the University of Iowa. The *ad hoc* committee recommended the initiation of such a program, specifying that the program should be at a baccalaureate degree level.

Broad objectives of the program, consistent with Iowa law and guidelines of the AMA Council on Medical Education, were developed by a committee of the College of Medicine under the guidance of A. W. Horsley, M.D., then Assistant Dean for Allied Health Programs, and T. D. Aschenbrener, a graduate of the PA Program at Duke University. Full accreditation of the PA Program was ultimately granted in March, 1975, indicating that the program meets all requirements established by the AMA, the American Academies of Family Physicians and Pediatricians, the American College of Physicians and the American Society of Internal Medicine.

The first class of 10 students was graduated from the program in the fall of 1974. One of these graduates is fulfilling an obligation to serve as a PA at the Mennonite Mission in Puerto Rico, seven have located in the State of Iowa and one graduate is employed in a primary care setting in Rock Island, Illinois. Five of the graduates are in practice in Iowa towns of less than 10,000, two of these with populations below 1,000. It would seem clear, therefore, that the admission policy stipulating preference to qualified candidates who indicate a willingness to serve in rural areas has proven essentially successful in achieving one of the primary goals of the program: that is, to train persons to assume a high degree of responsibility in primary health care under the physician's direction and supervision in rural areas or settings with a high population to physician ratio.

## CURRICULUM

Since its inception, the educational curriculum of the two-year program has changed significantly in design but not in philosophy. The schedule is summarized in Table 1 and may be considered to have three phases.

*Basic Sciences—Phase I*

The physician's assistant must have a sound basic education and facility with the written and spoken word. The PA student should know the principles of the basic science disciplines and be able to use that knowledge to analyze commonly occurring problems in primary care. Therefore, coursework in *Phase I (Basic Sciences)* is orga-

Dr. Montgomery is Associate Dean, Academic Affairs, at the University of Iowa College of Medicine and Director of the Physician's Assistant Program. Dr. Oliver is Associate Director and John Gerstbrein is Clinical Coordinator of the Physician's Assistant Program.

TABLE I

CURRICULUM SUMMARY OF THE TWO YEAR PHYSICIAN'S ASSISTANT PROGRAM AT THE UNIVERSITY OF IOWA*

| Phase I Didactic Basic Sciences | | | | | | | | Phase II ICM | | | | | Phase III Clinical Rotations | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Year 1 | | | | | | | | | | | | | Year 2 | |
| June | July | Aug. | Sept. | Oct. | Nov. | Dec. | Jan. | Feb. | Mar. | Apr. | May | | June ← 12 months → | May |
| Gross Human Antomy (6) | | | Living Anat. & Physical Diag. (2) | | | | C | | | | | | Clinical Rotations | |
| Biochemistry (3) | | | | Clin. Path. Lec. (2) | | | H | | | | | | Family Practice | 8 weeks |
| Human Physiology (4) | | | | Micro. Lec. (2) | | | R | Introduction to Clinical Medicine and Physical Diagnosis (16) | | | | | General Surgery | 8 weeks |
| | | | | Clinical Pathology Lab / Micro. Lab | | | I | | | | | | Internal Medicine | 8 weeks |
| | | | | | | | S | | | | | | Pediatrics | 8 weeks |
| | | | | Pharmacology (5) | | | T | | | | | | Obstetrics & Gynecology | 4 weeks |
| | | | | Law and Medicine (1) | | | M | | | | | | Psychiatry | 4 weeks |
| | | | | Seminar (1) | | | A | | | | | | Elective 1 | 4 weeks |
| Human Pathology/Case Analysis (4) | | | | | | | S | | | | | | Elective 2 | 4 weeks |
| | | | | | | | B R E A K | | | | | | | |

( )—Denotes semester hours credit.
*—This is a summary of the 1974-1976 curriculum. It is reviewed yearly.

nized to develop the basic concepts in relationship to each other and with continuous application to the solution of health related problems. Also, the topics and practical skills in Phase I were selected to prepare the student for the Phase II (Introduction to Clinical Medicine and Physical Diagnosis). An analysis of the learning objectives for the clinical practice rotations, Phase III, was used to enrich the offerings in Phase I.

Basic sciences courses are offered over a 28-week period without regard to semester breaks and commence in June with the University Summer Session. The courses in *Biochemistry and Physiology* are integrated and continue for four weeks into the fall semester. The sequence of topics in Physiology-Biochemistry is followed as closely as possible by *Gross Anatomy,* which is offered for the first 12 weeks using prosections for the most part, although cadavers are available to the students for dissection when appropriate. Formerly Gross Anatomy was taught by dissection, which resulted in a loss in integration with Biochemistry-Physiology. The last four weeks of the Biochemistry-Physiology course overlap *Pharmacology* and during this period the topics of most common interest (autonomic and central nervous system) are studied jointly.

*Microbiology-Clinical Pathology* subjects are integrated where possible and follow Biochemistry-Physiology for 12 weeks. Some integration of Microbiology and Pharmacology is achieved in such topic areas as antibiotics. Clinical Pathology and Medical Microbiology reinforce certain theoretical concepts as well as enable the student to develop practical skills in commonly used medical laboratory procedures. The *Pathology* course covers general and systemic pathology over the entire 28-week period. This course is a programmed presentation emphasizing a conceptual approach to human disease by using tapes and slides, with discussion of clinical cases taking place during the last 16 weeks of the semester. The *Living Anatomy* course is similar to that given the first-year medical student and is designed to introduce the student to the skills necessary to perform a physical examination, emphasizing the ability to describe accurately any abnormalities that are found. Students serve as "patients" for each other during this course. Emphasis is placed both on abnormal and pertinent negative findings.

*Introduction to Clinical Medicine and Physical Diagnosis (ICM)—Phase II*

Material presented in Phase I prepares the student for the *Introduction to Clinical Medicine and Physical Diagnosis* sequence in which contact is made with a variety of patients under the supervision of clinical faculty. Skills in history taking and physical examination are developed further. This 16-week course is taken with the medical students and provides the opportunity for a symbiosis that continues in the clinical clerkships and in practice. The course is a massive interdisciplinary effort, serving to correlate

the basic sciences core of material with clinical experience. It brings together the faculty of all departments to review medicine in organ systems, in topics that span multi-organ systems, and in humanistic and behavioral studies. At the end of the course the student is evaluated to determine comprehension of factual knowledge and the level of skill in history taking and physical examination.

At various times during Phases I and II instruction is given to enhance the understanding of the *organization and administration of health care systems* and the concepts of *law and ethics* as they relate to medicine.

*Clinical Clerkships—Phase III*

The *Clinical Phase* (III) consists of supervised rotations in required and elective specialties (Table 1). These rotations, of either four or eight weeks duration, allow the student to apply the knowledge gained in the didactic and preclinical phase of the program and to develop additional skills through individual, supervised instruction. The rotations are designed to provide an opportunity for each student to become proficient in taking histories and performing physical examinations for patients with various diseases. In-patient clinical training is provided within the University of Iowa Medical Center and affiliated hospitals, together with the Muscatine Hospital through association with the Model Health Care Clinic in that city. Additional clinical experience is obtained by placing students with selected physician preceptors in private practice throughout the State.

The clerkship year is important not only for the development of skills and sensitivities to the needs of patients but also for the realization of the role the physician's assistant fulfills in the primary care setting. The students and the preceptors must titrate the enthusiasm of the clinical experience with the recognition of the dependent role of the PA to the supervising physician. For each clerkship the student and preceptor are provided with written learning objectives that have been developed by members of the faculty of the College of Medicine in consultation with the faculty of the Physician's Assistant Program. The assistant must be trained to function in the practice setting with the greatest possible competence in order to assure employing physicians, patients and all others that the best possible care is being provided. However, in the cascade of any referral system, it is as important to understand the limitations of training as to know what one can do competently. So it is with the physician's assistant and the supervision provided by the employer.

## CERTIFICATION AND LICENSING

Throughout the 24 months of training students are evaluated both by written examinations and by observation of performance of various skills, particularly the patient interview and the physical examination. The final examination attempts to measure the success with which the student has mastered the objectives of the Iowa Physician's Assistant Program:

*"Following completion of this program, the physician's assistant will be able to perform the more routine tasks of health care management which the primary-care physician presently performs (allowing him greater freedom and more time for other tasks). The physician's assistant will act in a professional manner, practicing good interpersonal relationships by being able to effectively teach, interact, organize and integrate appropriate matters and situations, being sensitive to effects of illness on the patient and the family of the patient, and at all times demonstrating an awareness of the limitations of training that require reference to the supervising physician."*

Upon graduation the student receives a certificate and, when University baccalaureate requirements have been met, the student receives a Bachelor of Science degree from the College of Medicine. The graduate must then demonstrate proficiency to the National Board of Medical Examiners in a two-day examination covering factual knowledge, patient management problems and the work-up of two patients. Finally, the graduate must be approved to practice *with a specific physician* by the Iowa State Board of Medical Examiners in accordance with the Act of 1971.

## FUTURE TRENDS

Much has been written about the physician's assistant since 1964 when the original program at Duke University was being designed. Many studies have documented the acceptance of the concept. The greatest debate continues to center on implementation of the concept, particularly the problem of supervision of the physician's assistant. It is important, and continuously stressed in the training of our students, that they must al-

ways be subject to appropriate and adequate supervision. In this way we are unrelenting that both the physician and the assistant are responsible for maintenance of on-going supervision. Mutual understanding and respect for each other's professional capabilities must be established for the extender principle to be effective and efficient.

At this time we anticipate that 18 students will graduate from the program in August, 1975 and will be seeking positions. Our Program Office will be pleased to assist any physician in the search for an assistant; for information call 319-353-5711.

## IOWA MEDICAL MISCELLANY

*(Continued from page 125)*

**PEER REVIEW IMMUNITY . . .** Legislative measure granting immunity for peer review participation is receiving principal impetus from Iowa Dental Association. IMS and IDA officials met in late February to review this and other items of mutual interest.

**FOUNDATION . . .** Iowa Foundation for Medical Care submitted its application for conditional PSRO status in late February. Designation is anticipated sometime between April and August.

**PRACTICE MANAGEMENT . . .** IMS Board of Trustees has authorized planning for a Practice Management Workshop for interested Iowa physicians either in the fall of 1975 or spring of 1976.

**BANQUET HEADLINERS . . .** Mrs. Mary Louise Smith, chairman of the Republican National Committee, and Malcolm Todd, M.D., AMA president, will participate in Delegates' Banquet April 30 in Des Moines. 1975 Society awards will be announced on this occasion.

**IMPAC BOARD . . .** New appointees to Board of Directors of the Iowa Medical Political Action Committee include Milford Hayden, M.D., Cherokee; Ed Grossman, Jr., M.D., Orange City; Mrs. Renee Robinow, Des Moines, and Mrs. Elaine Olsen, Minden.

**FOR DIABETIC YOUTH . . .** The Iowa Camp for Diabetic Youth, Camp Hertko Hollow, will occur June 22-28 at the Des Moines YMCA Camp. Children ages 8-16 are served. For information, contact American Diabetes Association (Iowa Affiliate), Iowa Lutheran Hospital, University at Penn, Des Moines 50316.

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*Dosage and Administration:* The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

*How Supplied:* Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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# Preceptorships in Primary Care: University of Iowa Experience

RICHARD M. CAPLAN, M.D.
Iowa City

*Exposure to primary care is on the increase with MECO, required and elective preceptorships and residencies. This activity represents an important step toward relieving numerical and geographical shortages of primary care practitioners in Iowa communities.*

In the summer of 1952 The University of Iowa College of Medicine began a general practice preceptorship for medical students. A cooperative arrangement had developed with the Iowa Academy of General Practice, the Iowa Medical Society and the College of Medicine in which each student was required to spend a four-week preceptorship with an Iowa general practitioner during the summer between the third and fourth years of the curriculum. This report tells how that experience evolved in the subsequent 22 years, and something more of its present operation and degree of success.

In the years after 1952, especially in the 1960's, the administration of the program grew increasingly "flexible" so that by 1970 an appreciable number of the students were fulfilling their curricular obligation by an experience that was geographically outside of Iowa (or even outside the United States) and in almost any domain of medical experience (including occasional research activities). By 1970, however, the discipline of family practice had evolved from its previous incarnation as general practice, and the public, the Congress, and many medical schools were increasingly realizing the acute numerical and geographical insufficiencies of our health care system in providing what has come to be known as primary care.

In 1971, therefore, the Preceptorship Committee of the College of Medicine, with approval of the Education Committee and general faculty, and in consultation with the Preceptorship Committee of the Iowa Medical Society, modified its practices about the preceptorship. The student would henceforth take the preceptorship in a *primary care discipline* (family practice, general internal medicine, or general pediatrics) *within* the United States, *during* the third year of the new curriculum which began in 1969, and for a period of *two weeks* rather than four.

The 1971-75 data about the numbers of students, discipline chosen, and whether in Iowa are displayed in Table I. It is apparent that the students have tended in great majority to select a family practice setting in Iowa.

## STATE INSTRUCTIONAL GOALS

Until 1971 the College of Medicine made no explicit statement about what it wanted the required preceptorship experience to accomplish—nor did it regarding any other part of the curriculum, either. At that time, however, a concerted effort was made, under the aegis of the Education Committee, to state instructional goals clearly and precisely for all of the required medical courses. The Preceptorship Committee developed a statement of specific goals for the student to achieve in the preceptorship. These goals are provided to the student and his preceptor shortly before

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF APRIL, 1975.

TABLE I

REQUIRED PRECEPTORSHIP IN PRIMARY CARE

| Class of | Class Size | % of Preceptorships In Iowa | % of Preceptorships Not in Iowa | % of Total in Fam. Prac. | % of Total in Int. Med. | % of Total in Peds. | No. of Iowa Preceptors | No. of Iowa Communities |
|---|---|---|---|---|---|---|---|---|
| 1972 | 148 | 84.0 | 16.0 | 74.7 | 19.9 | 5.5 | 101 | 53 |
| 1973 | 145 | 86.2 | 13.8 | 76.6 | 11.0 | 12.4 | 125 | 65 |
| 1974 | 157 | 89.1 | 10.9 | 77.7 | 11.5 | 10.8 | 107 | 62 |
| 1975 | 146 | 95.9 | 4.1 | 87.7 | 4.8 | 7.5 | 103 | 61 |

the preceptorship begins. At the end of the experience the student completes an evaluation form, part of which involved the student's rating of how well each of the objectives was fulfilled during his particular preceptorship. The student's ratings are then returned to the preceptor for his information so he may consider how to improve any aspect of the experience which the student considered weak. The pooled student rankings provide the Preceptorship Committee and the College of Medicine an overall measure of how well the total program is achieving its objectives. The averages of the responses for the class of 1975 (which took the required preceptorship during the 1973-74 academic year) are shown in Table II. It appears to the Preceptorship Committee that the experience is reaching its goals at a satisfactory level, although there is room for improvement. The students of that class rated the experience overall as highly valuable in 65% of instances, moderately valuable in 29%, undecided in 2%, of some value in 4%, and of no value in only 1 instance. This good record is a tribute to the many devoted practitioners who serve as preceptors.

Beginning in the autumn of 1972 a grant was obtained from the Bureau of Health Manpower Education to provide funds for stimulating elec-

TABLE II

| THE DEGREE TO WHICH THE REQUIRED PRECEPTORSHIP FULFILLED ITS EDUCATIONAL OBJECTIVES RATINGS BY CLASS OF 1975 | *Average Rating (N = 144)* 5 = highest rating 1 = lowest rating |
|---|---|
| Following completion of the preceptorship the medical student should be able to demonstrate an understanding of the role of the primary physician as he practices in a setting other than a large teaching hospital. The student should develop insight into primary medical practice, management and economic problems of private practice, and the role of the family physician in the community. He should also develop some understanding of the implications of primary care upon the physician's own life style and demands placed on the physician's family. After completion of the preceptorship, the student should be able to: | |
| 3.99 | 1.0 Differentiate between the characteristics of a medical practice which are common to all fields of medicine and those which are unique to primary care. |
| 4.55 | 1.1 Identify the most common forms of illness seen in the practice of a primary physician. |
| 4.24 | 1.2 Demonstrate knowledge of the common diagnostic and therapeutic procedures performed by the primary physician, such as routine laboratory screening, tonometry, sigmoidoscopy, office bacteriology and minor surgery; and participates to the extent of his ability as determined by the preceptor. |
| 4.11 | 1.3 Describe the role of the primary care physician as a coordinator of health care and his relation to other members of the health care team. |
| 3.83 | 1.3.1 Describe the cooperative relationships of a partnership or group in the care of an individual patient or family. |
| 4.32 | 1.4 Examine the doctor-patient relationship as it pertains to the primary physician and how this differs from the physician practicing a referral specialty. |
| 3.82 | 1.4.1 Describe how each of these physicians approaches diagnosis and therapy. |
| 4.12 | 1.4.2 Identify the role of the primary care physician in counseling and advising the patient and patient's family in cases of serious illness in which medical and surgical consultation is required. |
| 4.04 | 1.4.3 Describe proper method for referring patients to a consultant and the relationship between the referring physician and his specialty colleague. |
| 3.89 | 1.5 Identify medical community responsibilities. |

TABLE II (Continued)

| | |
|---|---|
| 3.48 | 1.5.1 Attend medical and specialty society meetings. |
| 3.63 | 1.5.2 Participate in medical staff activities of the community hospitals. |
| 3.28 | 1.5.3 Cite responsibilities to other health personnel in the community, for example teaching first aid, student nurses, etc. |
| 3.82 | 1.5.4 Describe potential positive and negative public relations and experiences of the primary physician for the general medical profession. |
| 3.11 | 1.5.5 Cite data on health-manpower needs of the state and nation, and discuss these needs and influences in the geographical setting of his preceptorship. |
| 4.13 | 1.6 Differentiate between ethical and non-ethical practice. |
| 4.48 | 1.7 Recognize the life-long need for continuing education when he is a practicing physician. |
| 3.85 | 1.7.1 Discuss five methods of continuing education that may be frequently utilized by the practicing physician. |
| 3.63 | 1.7.2 Describe the process of patient care appraisal, and how it relates to quality-of-care assessment and continuing education. |
| 3.39 | 1.7.3 Describe the principles of peer review and the issues involved in certification and re-certification of the practicing physician. |
| 4.47 | 1.8 Describe the satisfaction which can be gained through practice as a primary physician. |
| 3.90 | 1.9 Describe those factors which will lead to the selection of a field of medicine most appropriate to his personality and interests. |
| 3.98 | 2.0 Examine office management procedures. |
| 4.12 | 2.1 Discuss the financial aspects of an office practice, including charges and billing. |
| 3.18 | 2.1.1 Describe accurately one type of billing procedure, and can identify two additional billing methods. |
| 3.25 | 2.1.2 Describe the principles of medical insurance and third-party billing, and indicate some of the problems and hidden costs involved. |
| 3.45 | 2.2 Identify the various systems for preparing and maintaining medical records, with special emphasis on the advantages of the problem-oriented medical record. |
| 3.65 | 2.3 Identify the problems associated with scheduling appointments and discuss methods to solve them. |
| 3.42 | 2.4 Recognize factors to be considered in planning an office, such as patient flow patterns, noise control, etc. |
| 3.87 | 2.5 Recognize personnel problems in managing an office. |
| 4.08 | 2.5.1 Describe the variety of office personnel necessary in an average primary physician's office, and the job descriptions for each. |
| 3.27 | 2.5.2 Identify the fringe benefits, work schedules, and salary ranges for office personnel. |
| 3.72 | 3.0 Discuss the economics of medical practice. |
| 3.57 | 3.1 Specify the factors to be considered in establishing and operating partnerships, group practices or professional corporations. |
| 3.76 | 3.2 Identify those factors contributing to office costs. |
| 2.86 | 3.3 Describe the need for estate planning. |
| 3.24 | 3.4 Identify the need for, and cost of, malpractice insurance and various other types of office insurance. |
| 4.27 | 4.0 Examine the role and life style of the primary physician. |
| 4.09 | 4.1 Differentiate between life in the home of the physician and the non-physician. |
| 4.23 | 4.1.1 Identify time allocations for work and free time. |
| 4.05 | 4.1.2 Discuss the implications which the respect and standing given to the physician by the community have upon the physician. |
| 3.90 | 4.2 Identify the civic and social responsibilities in the community, such as local government, church organizations, school board, chamber of commerce, service clubs, youth activities, membership in political parties, etc. |
| 3.48 | 4.3 Describe the spouse's role in regard to the family and the community. |
| 3.28 | 4.4 Identify and discuss the opinions of the members of the physician's family in regard to their community. |

tive preceptorships in primary care. These newer preceptorships vary in duration from 4 to 12 weeks with most students choosing 4 weeks. The number of students choosing this additional preceptorship since its onset is shown in Table III.

The distribution of both required and elective preceptorships served in Iowa during the 1973-74 academic year is shown in Figure 1.

The development of this new preceptorship provides a valuable link to complete a chain of elective opportunities for students to experience medical practice in Iowa communities. It begins with the "MECO" ("Medical Education-Community Orientation") project first developed by

TABLE III

SENIOR STUDENT ELECTIVE IN PRIMARY CARE PRECEPTORSHIPS

| *Academic Year* | *No. of Students* | *No. of Communities* |
|---|---|---|
| 1972-73 | 10 | 10 |
| 1973-74 | 26 | 22 |
| 1974-75 | 22 | 18 |

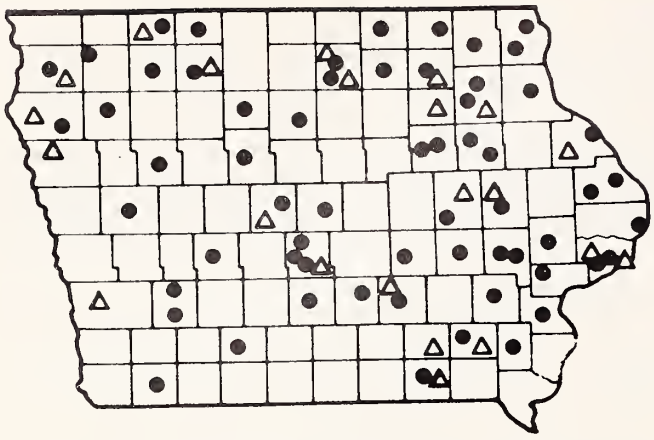


Figure 1. Third-year required preceptorships involved 105 Iowa physicians in 61 communities and served 141 medical students. Dots indicate the locations. The fourth-year elective preceptorship drew 26 medical students and involved that many preceptors in 22 Iowa communities. Triangles identify these communities.

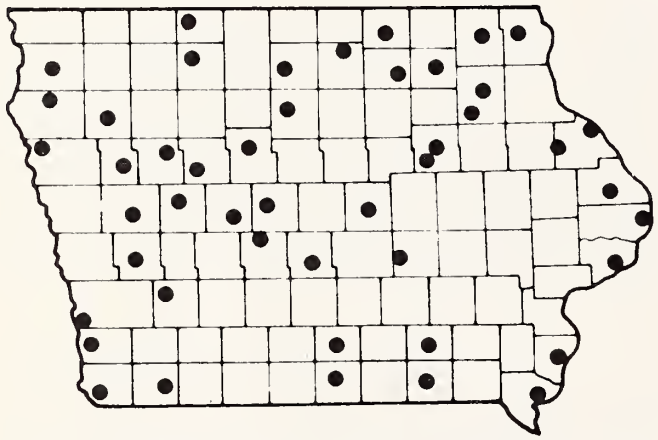


Figure 2. Eighty-one medical students participated in the 1973 MECO (Medical Education-Community Orientation) project. The students spent a portion of the 1973 summer in 47 Iowa communities.

the Student American Medical Association for the Summer of 1969. The MECO project brings post-freshman students into Iowa's community hospitals for a 10-week learning experience. A small number of Iowa students and hospitals participated in the summer of 1970 as a pilot venture. Its success, followed by a full year to develop publicity and enrollment of community hospitals, has led to a large growth of this voluntary, non-curricular experience. Table IV provides data about the numbers involved. Figure 2 shows the distribution of students working in the MECO project during the summer of 1973.

TABLE IV

POST-FRESHMAN STUDENTS PARTICIPATING IN MECO

| Summer of | No. of Students/ Class Size | No. of Communities | No. of Hospitals |
|---|---|---|---|
| 1971 | 47/144 | 31 | 33 |
| 1972 | 64/146 | 32 | 62 |
| 1973 | 81/170 | 47 | 55 |
| 1974 | 81/177 | 48 | 53 |

### PRIMARY CARE TRACK

The potential track of experience for primary care, then, involves these activities which a student may elect in one or some combination of Iowa communities: MECO → 3rd year required preceptorship in primary care → 4th year elective in primary care → postgraduate residency in primary care → practice in an Iowa community. It is still too soon to know the ultimate outcome of this chain, or the degree to which students will follow the implied pathway to its desired ultimate conclusion of practice in Iowa.

The College of Medicine is optimistic that such patterns of training location will affect favorably Iowa's medical manpower needs. For example, 76 physicians are taking family practice residencies in Iowa in the 1974-75 year (43% of them graduates of the University of Iowa College of Medicine), compared to zero in 1970 (for lack of training programs). Such information suggests that educational opportunity plus the cooperation of many community practitioners and hospitals will make a continuing important contribution toward relieving the numerical and geographical shortages of primary care practitioners in Iowa communities.

## THANKS TO PRECEPTORS

On the adjoining page are those Iowa physicians who have served as preceptors during the 1973-74 academic year. The preceptor program is an important element in the U. of I. outreach effort. It permits students to have a look at clinical problems away from the academic health center.

The College of Medicine is grateful to these busy, practicing physician teachers.

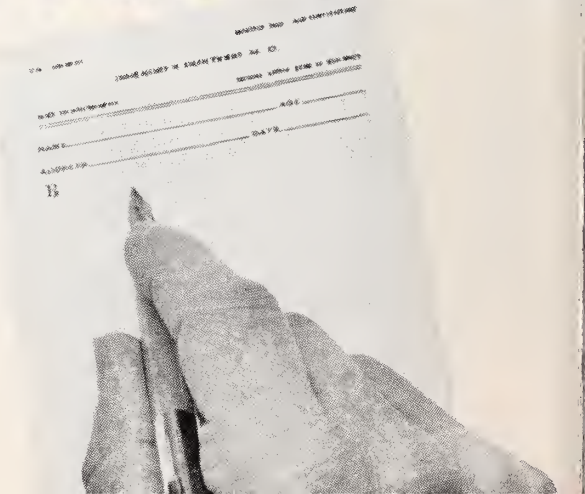
## 1973-74 PRECEPTORS FOR THIRD YEAR REQUIRED PRECEPTORSHIP

Ames ..... Louis Banitt, M.D.
George Hegstrom, M.D., H. H. Hildebrand, M.D., Paul Koellner, M.D.
Ankeny ..... Rodney Carlson, M.D.
Lawrence Gray, M.D.
Atlantic ..... Keith Swanson, M.D.
Bettendorf ..... Alan Swearingen, M.D.
Bloomfield ..... Phillip Caster, M.D.
W. David Haufe, M.D.
Boone ..... James R. Hill, M.D.
John R. Murphy, M.D.
Burlington ..... J. H. Murray, M.D.
Cedar Falls ..... R. N. Bremner, M.D.
Cedar Rapids ..... Carl Aschoff, M.D.
Thomas McIntosh, M.D., Robert Swaney, M.D., James Utter, M.D., James Ziska, M.D.
Cherokee ..... James Harten, M.D.
Clarence ..... George Utley, M.D.
Clarinda ..... Kenneth Jensen, M.D.
Clinton ..... G. L. York, M.D.
Cresco ..... Frances Klingle, M.D.
Creston ..... Larry Goetz, M.D.
Richard Wilker, M.D.
Davenport ..... John C. Barker, M.D.
Peter Jerome, M.D., E. A. Motto, M.D., Charlotte Rosendorf, M.D., F. W. Smith, M.D.
Decorah ..... James Bullard, M.D.
David Wright, M.D.
Denison ..... Daryll Crabb, M.D.
Des Moines ..... Robert Anderson, M.D.
Daniel Glomset, M.D., Don Green, M.D., Joel Linford, M.D., Stewart Olson, M.D., Y. Prusak, M.D., John Uchiyama, M.D.
Dubuque ..... Robert Melgaard, M.D.
Eagle Grove ..... Dale Harding, M.D.
Emmetsburg ..... C. C. Moore, M.D.
L. E. O'Connor, M.D.
Estherville ..... E. K. Vaubel, M.D.
D. E. Wolters, M.D.
Fairfield ..... C. F. Watson, M.D.
Fayette ..... Scott Linge, M.D.
Fort Dodge ..... Gary LeValley, M.D.
Jess Landhuis, M.D., Sara Sutton, M.D.
Grinnell ..... Ray Light, M.D.
B. G. Wiltfang, M.D.
Griswold ..... B. J. England, M.D.
Guttenberg ..... Mike Downey, M.D.
Hartley ..... Ivan Brown, M.D
Humboldt ..... James Coddington, M.D.
Independence ..... Paul J. Leehey, M.D.
Indianola ..... S. F. Yugend, M.D.
Iowa City ..... O. C. Beasley, M.D.
Craig Champion, M.D., Anthony Colby, M.D., Thaddeus Bozek, M.D., Victor Edwards, M.D., Larry Rigler, M.D., Charles Eicher, M.D., Loraine Frost, M.D., Elmer Groben, M.D., Wayne Tegler, M.D.
Jefferson ..... L. Marshall, M.D.
Kalona ..... Dwight Sattler, M.D.
Knoxville ..... D. A. Mater, M.D.
Lansing ..... Robert G. Love, M.D.
LeMars ..... Donald Faber, M.D.
Lone Tree ..... Keith Mills, M.D.
Maquoketa ..... Paul Gjerstad, M.D.
Clifford L. Rask, M.D.
Marengo ..... Burns Byram, M.D.
Mason City ..... John Baker, M.D.
Mt. Pleasant ..... Warren Scott, M.D.
Muscatine ..... V. W. Swayze, M.D.
New Hampton ..... James Carr, M.D.
Orange City ..... R. J. Hassebroeke, M.D.
Osage ..... Thomas Place, M.D.
William Spencer, M.D., Mark Steine, M.D.
Oskaloosa ..... Keith Campbell, M.D.
Preston ..... James Cahill, M.D.
Rockford ..... Russell Barrett, M.D.
Sac City ..... Rodney Miller, M.D.
Spencer ..... Lyle Frink, M.D.
Ed Kelly, M.D.
Spirit Lake ..... Donald Rodawig, M.D.
Vinton ..... D. C. Weideman, M.D.
Wapello ..... Leslie Weber, M.D.
Waterloo ..... William Drier, M.D.
Robert C. Miller, M.D., Robert E. Morrison, M.D.
Waukon ..... Louis B. Bray, M.D.
West Des Moines ..... Roy Overton, M.D.
West Union ..... Larry Boeke, M.D.
Winthrop ..... A. E. Mayner, M.D.

## 1973-74 PRECEPTORS FOR FOURTH YEAR ELECTIVE PRECEPTORSHIP

Bettendorf ..... Alan Swearingen, M.D.
Bloomfield ..... Henry Perry, M.D.
Boone ..... John Murphy, M.D.
Cedar Rapids ..... Carl Aschoff, M.D.
Richard Quetsch, M.D.
Clear Lake ..... James Hendricks, M.D.
Council Bluffs ..... George Klok, M.D.
Davenport ..... Joseph Kehoe, M.D.
Erling Larson, M.D., Edwin W. Motto, M.D.
Des Moines ..... John W. Olds, M.D.
Dubuque ..... R. Melgaard, M.D.
Emmetsburg ..... R. L. Cozine, M.D.
Fairfield ..... William Baumann, M.D.
Keystone ..... William Steinbeck, M.D.
Le Mars ..... Donald Faber, M.D.
Mason City ..... George West, M.D.
New Hampton ..... James Carr, M.D.
Orange City ..... Paul Vander Kooi, M.D.
Oskaloosa ..... Sidney Smith, M.D.
Ottumwa ..... Edward Ebinger, M.D.
Sioux City ..... George Spellman, M.D.
W. K. Jackson, M.D.
Spirit Lake ..... Don Rodawig, M.D.
Waverly ..... James Rathe, M.D.
West Union ..... Larry Boeke, M.D.

# Bioequivalence



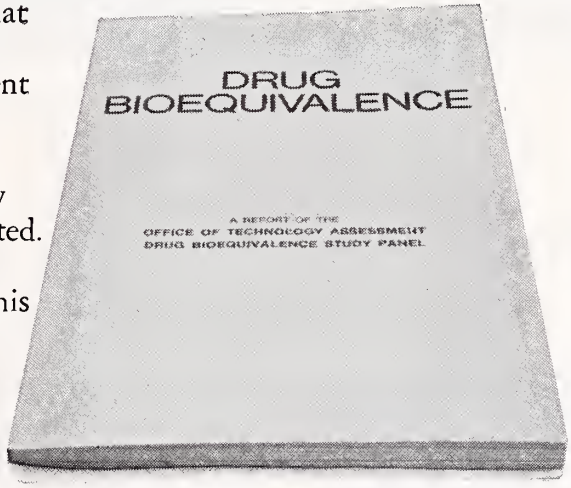
# the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.




"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P-M-A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

# protecting the integrity of your prescription

# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## ANNUAL UNIVERSITY ISSUE

The editors welcome contributions from the students and faculty of the University of Iowa College of Medicine to this issue of the JOURNAL. Each April we traditionally dedicate the JOURNAL to the School of Medicine. The reports from the faculty have supplemented the excellent scientific articles received and published during the entire year. So it is that this month we salute the School of Medicine.

The relationships of the academic physicians to the practicing physicians are varied and often misunderstood. Often there seems to be a degree of distrust between the two families; yet such need not be. Recently, I had an interesting conversation with a physician who has been in private practice for a very short time, after leaving the hallowed halls of an academic center. He very adequately contrasted the buffering affect of the institution upon his medical decisions with the necessity of standing on his own decisions in private practice.

A multidisciplined clinic has a similar degree of buffering. The private practitioner, whether he be solo or in partnership, must come to his decisions in a more individual manner, often without the immediate availability of consultation. He, therefore, may find it difficult to appreciate the more deliberate, sometimes slower, progression of decisions in the academic hospital.

Herein lies a basis for a program that has been used too infrequently. In this, faculty members will spend several days or weeks in the offices of a practitioner in a small town or city, learning what it's all about in private practice. By the same token, the practitioner may spend several days at the University Hospital absorbing refreshment from the fountains of academic medicine. Both groups prosper from such an arrangement—in medical knowledge as well as understanding each other's plight (or more desirable state).

In Iowa the relationships between the academic physicians and the practicing physician has been good. Some of the misunderstandings have been personal problems, rather than institutional policy. I would like to see even more liaison between the University and all hospitals of the state rather than with a few select hospitals. Programs for the medical students are being directed toward this end. Could not a "visiting professor" arrangement for one or two day stints be developed for some of the smaller hospitals as well. The five or six physicians of XYZ County Hospital might be just as desirous of a visiting professor as the 100-200 staff physicians of a large city hospital. Some might think this a waste of the manpower of one high on the academic ladder, but those five struggling, hard working family practitioners are very important people too, and they desire to be recognized on their own home ground, rather than having to leave their practices to go to the academic centers for additional training.

Our education patterns in the city will have to change during the next year. The unwise discontinuation of internships will change the complexion of training programs in some hospitals where there will be no formal residency training programs. Interns are a stimulus to the practicing physicians.

A new form of stimulation will be necessary, and we may have to turn to the academic centers for this . . . not at the academic center but from the center. Our need for continuing education will be ever increasing. Our search for knowledge will increase in the direction of the academic centers. College of Medicine, we salute you; we need you; and you need us.—M.E.A.

# how to ease your burdens as landlord

Obviously, your office is the place to practice your profession; not to deal with disgruntled tenants! Yet if you have real estate investments you may find a complaining renter sitting in your outer office, demanding to be seen!

Whether or not your investments include rental property, the point is you have to squeeze time in for them between patients, unless you have . . .

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Iowa Trust Departments understand the limitations on a professional person's time and have management programs tailored just for them. If it's rental property we have the experienced personnel to handle all the details . . . including broken plumbing fixtures!

Whatever the form of your investments, we'll handle the problems for you, collect income, keep the books and give you the information you'll need for your tax return.

**AND MUCH MORE!**

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*IOWA TRUST DEPARTMENTS CAN SAVE YOU TIME AND MONEY*

# The post-T & A patient:

## another type for TYLENOL® acetaminophen product

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

**References: 1.** Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

**Precautions and Adverse Reactions:** If a rare sensitivity reaction occurs, the drug should be stopped. Acetaminophen has rarely been found to produce any side effects.

**Elixir,** 120 mg./5cc. (alcohol 7%).
**Drops,** 60 mg./0.6cc. (alcohol 7%).
**Chewable Tablets,** 120 mg.

**Safer than aspirin, yet just as effective for relief of pain and fever**

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# SEEK LEGISLATION TO EASE LIABILITY DILEMMA

MEDICAL LIABILITY INSURANCE is as much or more of a priority issue as when it was the "In the Public Interest" topic last December. Its increasing scarcity continues to threaten the delivery of medical care in Iowa—and countrywide. These three vignettes reported to the Iowa Medical Society in recent weeks testify to the crucial nature of the problem.

- *You have heard all through medical school about the need for family practitioners in Iowa. You are ready to hang out your shingle but you are unable to get any liability insurance.*
- *You have moved to Iowa with a good practice record to join a well-established surgical group and the insurance company serving your new associates is unwilling to include you in the coverage program.*
- *You have had 22 claim-free years in medical practice and you are advised your liability insurance premium may increase from $1,680 to as much as $13,000 in 1975.*

These reports are disconcerting, to put it mildly. Two conclusions are quite evident:

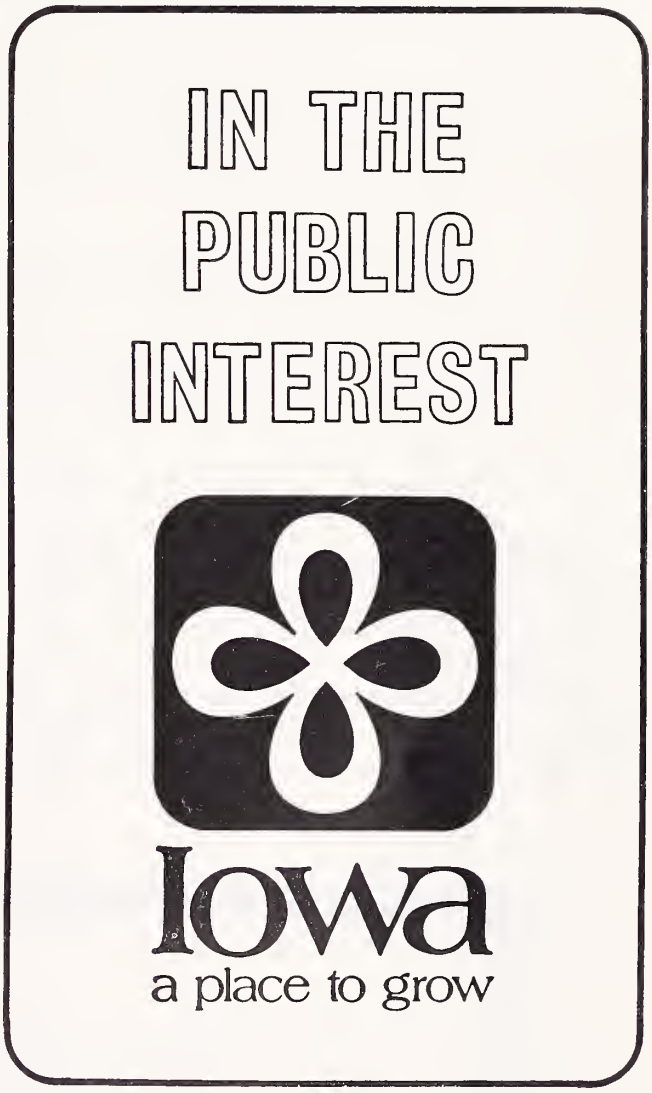
**1) The current very limited availability of professional liability insurance coverage is jeopardizing efforts to alleviate manpower problems and is thwarting attempts to secure more physicians for Iowa.**

**2) The ballooning expense of professional liability insurance must ultimately be passed along to Iowans in higher charges for medical services.**

Until recent months, at least in Iowa, the public has been only remotely aware of liability insurance matters as they apply to health care. The subject has been solely in the domain of physicians, hospitals and insurance companies. Now, however, it must be categorized as a pressing public issue.

To further understand the magnitude of the problem, consider these statistics: In 1965, reportedly, the cost per patient per day to cover professional liability premiums was 10 cents. This year each patient will pay $3.65 each day—at least in some sections of the country—to cover these premium costs.

What does the patient get in return for this investment of funds?




Roughly 16 cents. Only approximately 16 cents of every dollar spent for professional liability insurance ends up as direct payments to patients who suffer medical injury. The rest—84 cents—goes for plaintiff and defense lawyers, for costs of investigation, for medical witness fees, for insurance underwriting, etc.

Statistics such as these make one wonder about the system. Is there a need for a new approach that recognizes legitimate medical injury, recompenses the injured without undue delay, and does so at a rate commensurate with the seriousness of the injury? Such an approach is under consideration in several states—and the Iowa Medical Society is evaluating various proposals. Blueprinting and implementing such a system will take time.

Meanwhile, in an effort to restore and stabilize the medical liability insurance market for Iowa

physicians, the Iowa Medical Society is now pressing for enactment of six legislative measures it believes will have remedial value in the realm of negligence procedural law. Now before the Iowa General Assembly are proposals in the following areas:

1. *Contingency Fees.* This bill establishes a percentage schedule to guide the court in providing a fair compensation to the plaintiff's attorney. The percentage is scaled downward as the award increases.

2. *Statute of Limitations.* This change in the Iowa Code would set a 2-year limit on filing a claim beginning from when the claimant knew or should have known the existence of the possible negligent act. It also imposes a 4-year maximum filing time from the date of the surgery or treatment.

3. *Informed Consent.* This proposal assigns statutory significance to a written prior understanding with the patient and/or his relatives. It removes grounds for liability unless a guarantee or assurance of results is set forth in writing and is signed by designated individuals.

4. *Burden of Proof.* Among other things, this legislation limits the selection of expert medical witnesses to physicians licensed in Iowa and surrounding states who practice in the same specialty as the defendant.

5. *Ad Damnum Clause.* This bill precludes announcement of a stated dollar amount in a petition for damages. No newspaper or other public reference would be allowed inasmuch as damage payments are rarely made at the level initially noted.

6. *Collateral Source Rule.* This measure will prevent a claimant from receiving duplicate payments. It will require the reporting of medical and hospital expenses reimbursed by health insurance so that a second payment for these expenses can be avoided.

This request for legislative support is part of a broad program of the Iowa Medical Society to relieve the current liability dilemma. The Society has been pleased with the genuine interest of the members of the Iowa General Assembly. In addition to those senators and representatives who are bill sponsors, the Society is gratified by supportive indications which have come from other of Iowa's lawmakers.

It is hoped that many Iowa physicians will find it possible to visit personally with their individual state legislators about the merits of these measures.

★

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9132 Dorcas Street, Omaha, Nebraska Telephone: (Area Code 402) 393-5797
Mailing Address: Elmwood Station, Box 6076, Omaha, Nebraska 68106

# Morbidity Report for February, 1975

| Disease | Feb. 1975 | 1975 to Date | 1974 to Date | Most February Cases Reported From These Counties |
|---|---|---|---|---|
| Actinomycosis | 1 | 1 | | Buchanan |
| Adenovirus | 1 | 2 | 8 | Polk |
| Amebiasis | 1 | 2 | | Polk |
| Ascariasis | 1 | 1 | | Iowa |
| Brucellosis | 4 | 5 | 3 | Clayton, Dubuque, Tama |
| Chickenpox | 1378 | 2531 | 1950 | Black Hawk, Dubuque, Polk, Tama |
| Conjunctivitis | 147 | 270 | 101 | Johnson, Linn, Polk, Warren |
| Encephalitis Assoc. with Herpes simplex | 1 | 2 | | Iowa |
| Enteropathogenic *E. Coli* | 2 | 2 | 2 | Dubuque, Jackson |
| Erythema infectiosum | 11 | 20 | 49 | Dubuque, Greene, Guthrie |
| Gastrointestinal viral inf. | 3390 | 7905 | 2376 | Bremer, Chickasaw, Dallas, Floyd, Linn |
| Guillian-Barré syndrome | 3 | 3 | | Calhoun, Clinton, Story |
| Hepatitis, A (Infectious) | 23 | 38 | 62 | Linn, Montgomery, Page, Polk |
| Hepatitis, B (Serum) | 8 | 15 | 16 | Crawford, Dubuque, Johnson, Polk, Story |
| Hepatitis, type unspecified | 2 | 2 | 4 | Dallas, Scott |
| Histoplasmosis | 4 | 7 | 3 | Polk, Scott, Wapello |
| Impetigo | 75 | 140 | 61 | Linn, Mills, Winnebago, Winneshiek |
| Infectious Mononucleosis | 152 | 302 | 182 | Bremer, Johnson, Linn, Polk, Scott |
| Influenza, lab confirmed | 66 | 136 | 46 | Jackson, Johnson, Keokuk, Polk |
| Influenza-like illness | 13729 | 25490 | 51117 | Bremer, Johnson, Lee, Linn, Madison, Polk |
| Meningitis | | | | |
| Aseptic | 3 | 3 | | Floyd, Scott |
| Bacterial | 3 | 3 | 2 | Muscatine, Scott, Taylor |
| *H. influenza* | 2 | 3 | | Keokuk, Scott |
| Type unspecified | 10 | 15 | 8 | Scattered |
| Meningococcal Meningitis | 3 | 4 | 3 | Crawford, Keokuk, Warren |
| Meningococcemia | 1 | 1 | | Keokuk |
| Mumps | 151 | 226 | 674 | Louisa, Muscatine, Polk, Pottawattamie |
| Mycoplasma pneumoniae | 1 | 1 | | Johnson |
| Parainfluenza type 3 | 1 | 7 | | Woodbury |
| Pediculosis | 39 | 81 | 79 | Scattered |
| Pericarditis | 1 | 1 | | Polk |
| Pinworms | 2 | 5 | 18 | Polk |
| Pneumonia | 202 | 353 | 209 | Johnson, Polk, Scott |
| Rabies in Animals | 6 | 13 | 21 | Hardin, Jasper, Marion, Woodbury |
| Rheumatic fever | 3 | 5 | 32 | Bremer, Polk, Pottawattamie |
| Ringworm, body | 33 | 59 | 54 | Scattered |
| Ringworm, scalp | 3 | 3 | | Calhoun, Cerro Gordo |
| Rubella | 1 | 2 | 5 | Clarke |
| Rubeola | 27 | 27 | | Floyd, Harrison, Pottawattamie |
| Roseola | 2 | 2 | 5 | Allamakee, Bremer |
| Salmonellosis | 3 | 31 | 25 | Dubuque, Warren |
| Scabies | 63 | 94 | 28 | Clayton, Johnson, Wapello |
| Shigellosis | 9 | 16 | 19 | Dubuque, Linn, Scott, Story |
| Streptococcal infections | 1320 | 2320 | 2532 | Dubuque, Jackson, Johnson, Polk |
| Toxoplasmosis | 4 | 4 | | Dubuque, Lee, Pottawattamie, Woodbury |
| Tuberculosis, total ill | 5 | 10 | | Black Hawk, Polk |
| Tuberculosis, bact. positive | 2 | 6 | | Polk |
| Venereal Diseases: | | | | |
| Gonorrhea | 747 | 873 | 1016 | Black Hawk, Johnson, Linn, Polk, Scott |
| Syphilis | 35 | 40 | 85 | Black Hawk, Clinton, Linn, Polk, Woodbury |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | | | |
|---|---|---|---|---|---|
| Cytomegalovirus | 3 | ECHO 4 | 1 | Herpes zoster | 5 |
| Eaton's agent | 2 | Herpes simplex | 17 | | |

# There's a lot to be said about your future in medicine.

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# About IOWA Physicians

**Dr. Jon Blaschke,** Iowa City, plans to establish a cardiology practice in Elkader following his post-graduate work at University Hospitals. Dr. Blaschke will conduct cardiac clinics on a part time basis at Central Community Hospital in Elkader until he moves there permanently. . . . The Woodbury County Medical Society has elected **Dr. Dwayne Howard,** president; **Dr. Leonard Boggs,** president-elect; **Dr. Barry Knapp,** vice president; **Dr. John W. Scott,** secretary; **Dr. David G. Paulsrud,** treasurer; **Dr. James F. Boysen,** first trustee; and **Dr. Frederick M. Stark,** second trustee. All are Sioux City physicians. . . . **Dr. John Beattie,** who has practiced in Hamburg and Tabor the past two years, has joined the medical staff at Dallas County Hospital in Perry. . . . **Dr. Lee J. Marven,** Hartley, will soon join Emergency Medical Services Inc. in the Tidewater area of Virginia. Dr. Marven was recently elected to American College of Emergency Physicians. . . . **Dr. Donald M. Casady** joined Medical Associates in Iowa City in January. A native of Denison, Dr. Casady received the M.D. degree at U. of I. College of Medicine and interned at St. Francis Hospital Medical Center in Peoria, Illinois. . . . **Dr. Terry Sutton,** Fairfield, is 1975 president of Jefferson County Medical Society. Other new officers are—**Dr. James Dunlevy,** Fairfield, vice president; **Dr. Tom Wolf,** Richland, secretary; **Dr. W. C. Baumann,** Fairfield, delegate; and **Dr. Kirk Strong,** Fairfield, alternate delegate.

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The following Fort Dodge physicians participated in a recent adult education course for nurses on emergency care: **Dr. F. G. Dannenbring** spoke on "Pediatric Emergency Care," **Dr. J. G. McCarroll,** "Ob and Gyn Emergencies," **Dr. Jesse Landhuis,** "Metabolic Disorders Causing Coma and/or Shock," and **Dr. Donald Lulu,** "Trauma to the Central Nervous System, Coma and Neurogenic Shock." The program was conducted by the Adult and Continuing Education Division of the Iowa Central Community College. . . . **Dr. Steffen Helgaas** will begin a family practice in Orange City in May. A graduate of the University of Minnesota Medical School, Dr. Helgaas is currently in the Student Health Department at the University of South Dakota, Brookings, South Dakota. . . . **Dr. John Nolan,** Corning, has been named president of the Area 14 Health Planning Council. . . . **Dr. D. M. Eggers,** Marshalltown, was guest speaker at a recent meeting of Marshall County Child Study Group. Dr. Eggers' topic "A Child's First Exposure to the Facts of Reproduction." . . . At January meeting of Polk County Medical Society, **Dr. Donald C. Young** was chosen president-elect; **Drs. John I. Hostetter** and **Ronald K. Bunten,** trustees; **Dr. Donald L. Sweem,** councilor; and **Dr. Robert T. Brown,** secretary-treasurer. Named Life Members of the Society were **Drs. Walter Kirch, Joseph B. Priestley, Herbert A. Sohm** and **J. Fred Throckmorton.** All are Des Moines physicians.

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Clinton County Medical Society officers for 1975 are—**Dr. Margaret Emmons,** president; **Dr. Kerry Jensen,** vice president; **Dr. Salvador Borja,** secretary-treasurer; **Dr. G. T. Schmunk,** delegate; **Dr. George York,** delegate; **Dr. Dale Weber,** alternate delegate; and **Dr. Robert German,** alternate delegate. All are Clinton physicians. . . . **Dr. Roy Overton,** West Des Moines, described water test procedures and steps necessary to prevent pollution at recent Isaac Walton League meeting in Sigourney. Dr. Overton is state chairman for the Save Our Streams (S.O.S.) program of the Iowa Division of Isaac Walton. . . . **Dr. George Zibilich** was honored recently for his 21 years of service in Lone Tree. Dr. Zibilich has accepted a family practice position with a clinic in Indio, California. . . . **Dr. Larry D. Foster** has joined the Newton Clinic in family practice. A native of Ottumwa, Dr. Foster received the M.D.

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degree at U. of I. College of Medicine and interned in Fresno, California. Prior to accepting the Newton position, Dr. Foster practiced in Soledad, California. . . . The following Dubuque physicians have been named officers of Dubuque County Medical Society for 1975—**Dr. John Moberly,** president; **Dr. Robert G. Vernon,** vice president; **Dr. Donald L. Kahle,** secretary; and **Dr. Ross A. Madden,** treasurer. Delegates are **Drs. James W. White, Robert T. Melgaard** and **Kenneth K. Hazlet**; alternate delegate is **Dr. John S. Chapman.**

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At January meeting of Guthrie County Board of Health, **Dr. D. W. Todd,** Guthrie Center, was reappointed chairman and **Dr. W. A. Seidler,** Jamaica, was named vice chairman. . . . **Dr. and Mrs. Robert Schafermeyer,** Eldora, are conducting a 15-week adult education course on family health care. Dr. and Mrs. Schafermeyer have entitled the course, "The Way to Health—Care for Yourself and Those You Love." . . . **Dr. H. S. Jacobi,** Waterloo, was elected president of Visiting Nurses Association at recent annual meeting in Waterloo. . . . **Dr. Gerald Solomons** and **Dr. Charles Johnson,** professors in Department of Pediatrics at U. of I. College of Medicine, will be guest speakers at "The Vulnerable Child Workshop" on March 14 in Fort Dodge. . . . **Dr. Richard B. Trimble,** Mason City, has been certified as a diplomate in the subspecialty of rheumatology by American Board of Internal Medicine. . . . **Dr. John J. Dougherty** was named president of medical staff at St. Vincent Hospital in Sioux City; **Dr. Vernon G. Holt,** vice president; and **Dr. Sidney A. Cohen,** secretary-treasurer. All are Sioux City physicians.

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**Dr. Norman Bone,** Des Moines, has been named to new Alumni Board of Councilors of Northwestern University Medical School. Dr. Bone will represent NU medical graduates who practice in Iowa and Missouri. Board members will serve as consultants on school policies and goals. . . . **Dr. J. E. Whitmire,** Sumner, retired from the practice of medicine February 1. . . . **Dr. S. M. Haugland,** Lake Mills, is new director of Powell III, at Iowa Methodist Hospital in Des Moines. The unit provides for treatment of chemically dependent persons. Dr. Haugland practiced in Lake Mills for 14 years. . . . **Dr. P. T. Cawley** is new president and chief of the medical staff at St. Anthony Regional Hospital in Carroll. . . . **Dr. David G. Kundel** has joined the Radiology Department at Muscatine General Hospital. A U. of I. medical graduate, Dr. Kundel interned at Iowa Methodist Hospital in Des Moines and completed his residency at Case Western Reserve University Hospitals in Cleveland, Ohio. . . . **Dr. Charles E. Hartford,** associate professor in Department of Surgery at U. of I. College of Medicine, has been appointed by Governor Robert Ray to 15-member Emergency Medical Service Advisory Council.

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## DEATHS

**Dr. E. G. Nafziger,** 53, Siuox City, died January 25 at his home. Dr. Nafziger received the M.D. degree at Hahneman College in Philadelphia, Pa. Prior to locating in Sioux City, Dr. Nafziger practiced medicine at Battle Creek from 1958 until 1964.

**Dr. C. C. Hall,** 87, Maynard physician for 54 years, died January 23 at St. Mary's Hospital in Rochester, Minnesota. A 1919 graduate of U. of I. College of Medicine, Dr. Hall was a past president and secretary of the Fayette County Medical Society.

**Dr. William H. Harper,** 50, Keokuk, died at VA Hospital in Iowa City February 5. Dr. Harper received the M.D. degree at Howard University in Washington, D.C., and interned at Homer G. Phillips Hospital in St. Louis, Missouri. He joined his father, the late Dr. William H. Harper, Sr., in the private practice of medicine in Keokuk in 1949. Dr. Harper was a member of American Academy of Family Practice, American Medical Association, Southwest Clinical Society, National Medical Association and the N.A.A.C.P.

**Dr. Purl E. Reed,** 76, Council Bluffs, died at his home on February 18. Dr. Reed retired from the active practice of medicine in Council Bluffs in 1954.

**Dr. R. C. Mugan,** 61, Sioux City physician and surgeon for 35 years, died March 3 at a Sioux City hospital. Dr. Mugan received the M.D. degree at Creighton University Medical School in Omaha, Nebraska in 1938. He was a charter member of American Academy of General Practitioners; and a past president of Woodbury County Medical Society and St. Vincent Hospital medical staff.

**Dr. Robert S. Taylor,** 91, Davenport, died February 17 at his home. Dr. Taylor received the M.D. degree at Creighton University School of Medicine in Omaha, Nebraska. He retired from the active practice of medicine in Davenport in 1973.

**Dr. Harry Burns,** 82, died February 16 at Veterans Hospital in Des Moines. Dr. Burns, who retired as a general practitioner a year ago, received the M.D. degree at U. of I. College of Medicine. He was a Navy flight surgeon in World War I and a former examiner for the Federal Aviation Agency.

**Dr. Larry F. Catterson,** 77, Oskaloosa, died at Mahaska Hospital in Oskaloosa on February 19. Dr. Catterson received the M.D. degree at Harvard Medical School. He began his practice of medicine in New Sharon in 1926 and relocated in Oskaloosa in 1930.

**Dr. Benjamin D. Van Werden,** 71, Keokuk, physician for 35 years, died February 16 at University Hospitals in Iowa City. Dr. Van Werden received the M.D. degree at Louisiana State University. He served as resident surgeon at the Charity Hospital in New Orleans, and practiced medicine in Houston, Texas, for three years before locating in Keokuk in 1939.


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## INDEX TO ADVERTISERS


Air Force Medical Placement ..... 156

Burroughs Wellcome ..... 142B

Iowa Trust Association ..... 151

Lilly, Eli, & Company ..... 121

McNeil Laboratories ..... 152

Medical Protective Company ..... 154

Milwaukee Sanitarium Foundation ..... 138

Pharmaceutical Manufacturers Association ..... 148-149

Prouty Company ..... 159

Roche Laboratories ..... 122-123

Roerig, J. B., & Co. ..... 142D

Searle, G. D., & Co. ..... 142, 142A

Smith, Kline and French ..... 142C

Stockdale, Inc. ..... 158

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• **Physician Comments on CME**— Page 171
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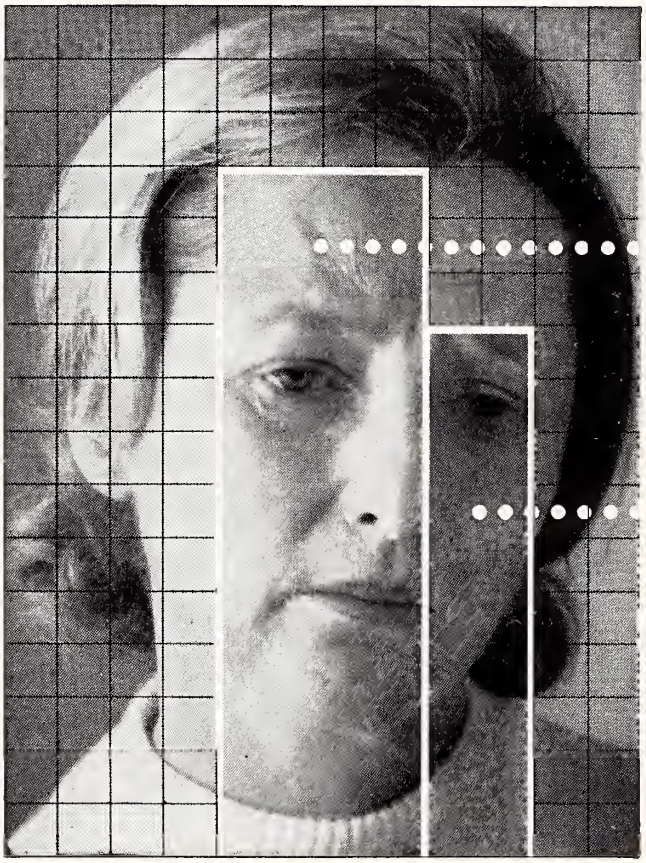
# Both often

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n provide relief for both—as
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ms associated with it are also
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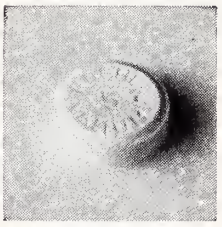

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with associated
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**ecautions:** If combined with other psy-
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yed; drugs such as phenothiazines,
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action. Usual precautions indicated in
tients severely depressed, or with latent
pression, or with suicidal tendencies.
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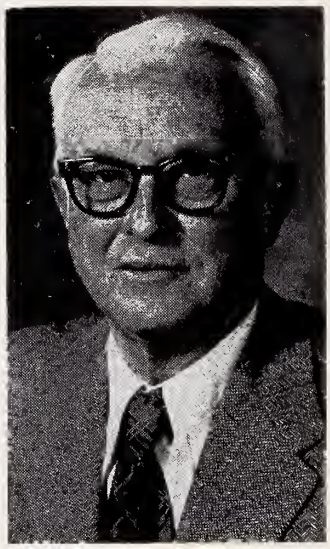
# President's Page



The traditional changing of the IMS guard will have occurred when these words are read. My friend and able colleague, Verne Schlaser, will have accepted the presidential gavel. I extend every good wish to him and the other 1975-76 Society officers.

The IMS scientific meeting, from which we have recently returned, was a success in that the committee selected interesting subjects and secured excellent speakers to discuss them. The meetings were well attended by the participants and there was some time for relaxation and getting acquainted with fellow Iowa physicians and their families.

During the past year there have been many frustrating problems to confront the Society officers: professional liability, continuing medical education, PSRO, AMA finances, hospital relationships and so on. Who knows what the passage of time will do to resolve, clarify or further complicate these and other areas. With National Health Insurance in the minds of many congressmen and bureaucrats, there will be increasing pressures and wedges in our relations with our patients. It is hoped we can keep in mind that patients' welfare is primary. We must keep our professional and compassionate attitudes.

Finally, may I acknowledge the long and dedicated service of Don Taylor. For nearly 30 years Don has served Iowa physicians. He will continue to serve, but for health considerations, he is relinquishing his position as Executive Vice-President. We look forward to having his further expertise and we are grateful for his terrific contribution to this point.

Sincerely,

Ralph L. Wicks

*Ralph L. Wicks, President*

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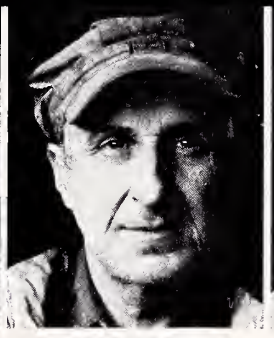
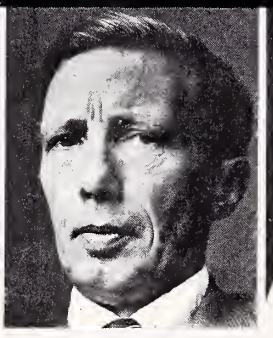


**The patient on uricosurics**

**The patient on anticoagulants**



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MAY 1975

## TABLE OF CONTENTS

Malaria in Iowa
Abner B. Preacher, M.D., and Robin D. Powell, M.D. . . . . 175

Lithium Use in Manic-Depressive Illness: Practical Aspects
Michael J. Taylor, M.D. . . . . 180

**EDITORIALS**

Houston, We've Gotta Problem . . . . 183

**SPECIAL DEPARTMENTS**

President's Page . . . . . 168

Question Box . . . . . 171

State Department of Health Revisions in Bacteriologic Screening for Gonorrhea . . . . . 172

Iowa Medical Miscellany . . . . . 174

Educationally Speaking . . . . . 184

In the Public Interest . . . . . 190

Medical Assistants . . . . . 192

About Iowa Physicians . . . . . 194

Deaths . . . . . 195

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# The Question Box

by CARL R. ASCHOFF, M.D.

*Dr. Aschoff is Chairman of IMS Committee on Medical Education and Hospitals and Director, Cedar Rapids Medical Education Program, Family Practice Section.*

**More physicians! This plea has been made by many in recent years. In your view, has the response been adequate?**

Yes. The response has been adequate but it has not been felt in many areas of the State even though the medical school is training and graduating more doctors than ever before. This increase in enrollment has not yet been reflected at the community level because the postgraduate training period is now longer. The problem of maldistribution of physicians still remains within our State. Though there is no easy solution, I feel in time this problem will be resolved. Studies have shown that 75-80% of physicians now in Family Practice residency training anticipate practicing in communities of fewer than 20,000 population and 50% or more anticipate practicing in communities of 10,000 or less population.

**There's been a heavy emphasis recently on medical education at all levels. How do you assess our progress?**

As a director of medical education in a Family Practice residency training program, I feel medical students today are better prepared and more knowledgeable upon graduation from medical school than in the past. I do have misgivings about the three-year medical school curriculum some medical schools have adopted. In interviewing prospective residents, we feel the three-year graduates are definitely at a disadvantage compared to the graduates of a four-year curriculum. Regarding medical education at the postgraduate level, an adjustment and re-establishment of priorities for specialty training and number of residents in each specialty should be seriously considered. The needs of the consumer must be put into this equation. In the area of continuing medical education for the practicing physician, a greater effort needs to be made at the local community level and continuing medical education should be based on demonstrated needs within the specific community.

**Your direct involvement is in family practice training. Are you satisfied with Iowa's progress in this area?**

Great strides have been made in the area of Family Practice residency training in Iowa under the firm leadership of Dr. Robert Rakel. However, to assure continued excellence, we must continually evaluate the quality of training we provide the residents in our community hospital settings. Efforts should be directed toward the encouragement and support of currently operating programs to make sure they are viable before additional new programs are undertaken.

**Please summarize your views as to continuing education for the physician. If some form of CME documentation is required, how can this best be done?**

Continuing medical education today is really the name of the game. Only by continuing medical education can any physician remain current in his/her practice regardless of specialty. We must continue to work toward providing the very best medical care for people at all levels of society. Each physician bears the responsibility of assessing his/her CME needs by some sort of practice profile. Then the necessary education must be sought wherever it can be obtained. Hopefully, much of this can be obtained within the physician's own community and community hospital setting. As to how continuing medical education can best be documented, I can at the moment think of no other way than the "honor system" where the physician records the hours denoted by date, time and place.

# State Department of Health

## REVISIONS IN BACTERIOLOGIC SCREENING FOR GONORRHEA

Since 1973 the Iowa State Department of Health, in cooperation with the State Hygienic Laboratory and certain local laboratories, has offered a bacteriologic culture service to aid physicians in the diagnosis of gonorrhea. Laboratory assistance is essential for detection and diagnosis because gonorrhea is asymptomatic in 80-90% of infected females.

A review of the results of this program reemphasizes that the disease is most prevalent in persons 30 years of age or less. The table below, which shows the results of tests of more than 35,000 women, reveals that only 69.3% of the total tested were in the age group of 30 years or less, but 94.9% of the positives were found in this age group.

By limiting the screening to those persons age 30 and under, the number of women tested could be decreased by approximately 30%, while the total number of persons detected would decrease by only about 5%.

In light of these data, *the Iowa State Department of Health is recommending that the target group for screening for gonorrhea be restricted to persons age 30 and under.* However, patients over 30 years of age should not be excluded from testing if they are sex contacts to known cases, or if they are symptomatic.

Based on results shown in the table and program expenses, the cost of detecting an individual with gonorrhea in the age 30 and under group by bacteriologic culture is approximately $100. The cost of detection of an infected person over 30 rises to more than $800. The recommended change

RESULTS OF SCREENING TESTS OF FEMALES FOR GONORRHEA

By Age Groups, Totals, Cumulative Totals and Cumulative Percentages
State of Iowa—January 1, 1974 to August 30, 1974*

| Age Group | Tests Total | Tests Cumulative Total | Tests Cumulative % | Positives Total | Positives Cumulative Total | Positives Cumulative % |
|---|---|---|---|---|---|---|
| 10 & under | 19 | 19 | .1 | 2 | 2 | .4 |
| 11-15 | 545 | 564 | 1.6 | 17 | 17 | 3.6 |
| 16-20 | 9,211 | 9,775 | 27.5 | 241 | 260 | 50.2 |
| 21-25 | 9,333 | 19,108 | 53.8 | 183 | 443 | 85.6 |
| 26-30 | 5,478 | 24,586 | 69.3 | 48 | 491 | 94.9 |
| 31-35 | 3,518 | 28,104 | 79.2 | 16 | 507 | 98.1 |
| 36-40 | 2,366 | 30,470 | 85.9 | 5 | 512 | 99.0 |
| 41-45 | 1,882 | 32,352 | 91.2 | | | |
| 46-49 | 1,098 | 33,450 | 94.3 | | | |
| 50 & over | 2,002 | 35,452 | 100.0 | 5 | 517 | 100.0 |

* January through June—local laboratories only. July through August—local laboratories and the state hygenic laboratory.

in emphasis will result in a considerable reduction in the cost of the program, with only a relatively minor decrease in its effectiveness.

Questions concerning this recommendation or other aspects of the bacteriologic culture service should be directed to the Venereal Disease Section of the Iowa State Department of Health (515-281-3031).

## Morbidity Report for March, 1975

| Disease | March 1975 | 1975 to Date | 1974 to Date | Most March Cases Reported From These Counties |
|---|---|---|---|---|
| Amebiasis | 2 | 4 | 2 | Boone, Cerro Gordo |
| Ascariasis | 3 | 4 | | Butler, Johnson, Linn |
| Brucellosis | 3 | 8 | | Dubuque, Tama |
| Cat Scratch Fever | 2 | 2 | | Black Hawk, Johnson |
| Chickenpox | 1547 | 4078 | 3335 | Black Hawk, Dubuque, Lee, Linn, Polk |
| Combined infestations | 7 | 7 | | Decatur |
| Conjunctivitis | 127 | 397 | 208 | Clinton, Johnson, Monroe, Warren |
| Encephalitis | | | | |
| Assoc. with Herpes zoster | 1 | 1 | | Carroll |
| Post infectious | 1 | 1 | | Lee |
| Erythema infectiosum | 43 | 63 | 108 | Dubuque, Madison, Palo Alto |
| Gastrointestinal viral inf. | 3145 | 11050 | 3817 | Bremer, Chickasaw, Floyd, Polk |
| Giardiasis | 1 | 3 | 5 | Des Moines |
| Hand, Foot & Mouth Disease | 2 | 3 | | Johnson, Polk |
| Hepatitis, A (Infectious) | 19 | 57 | 100 | Bremer, Howard, Linn, Ringgold |
| Hepatitis, B (Serum) | 4 | 19 | 24 | Dubuque, Linn, Muscatine |
| Hepatitis, type unspecified | 5 | 7 | | Linn, Mahaska, Palo Alto |
| Histoplasmosis | 2 | 9 | | Johnson, Polk |
| Impetigo | 75 | 215 | 118 | Calhoun, Carroll, Linn, Winnebago |
| Infectious Mononucleosis | 168 | 470 | 309 | Bremer, Johnson, Linn, Polk |
| Influenza, lab confirmed | 26 | 162 | 105 | Hardin, Johnson, Polk |
| Influenza-like illness | 6399 | 31889 | 87515 | Bremer, Chickasaw, Linn, Madison, Polk |
| Meningitis | | | | |
| Bacterial | 2 | 5 | 3 | Black Hawk, Poweshiek |
| *H. influenza* | 1 | 4 | 2 | Johnson |
| *Pneumococcal* | 1 | 1 | 1 | Henry |
| *Listeria monocytogenes* | 2 | 2 | | Black Hawk, Woodbury |
| *Streptococcus* | 1 | 1 | | Jackson |
| Type unspecified | 2 | 15 | 10 | Pottawattamie |
| Meningoencephalitis | 1 | 1 | | Clinton |
| Meningococcemia | 1 | 2 | | Warren |
| Mumps | 193 | 419 | 1149 | Louisa, Muscatine, Polk, Pottawattamie |
| Pediculosis | 40 | 121 | 155 | Cerro Gordo, Polk, Winnebago |
| Pertussis | 1 | 1 | 4 | Winneshiek |
| Pinworms | 6 | 11 | 26 | Polk, Wayne |
| Pneumonia | 91 | 444 | 350 | Scott |
| Rabies in Animals | 9 | 21 | 31 | Hardin, Keokuk, Plymouth, Washington |
| Ringworm, body | 37 | 96 | 70 | Scattered |
| Ringworm, scalp | 1 | 4 | | Calhoun |
| Rubella | 5 | 7 | 7 | Allamakee, Black Hawk, Chickasaw, Hardin |
| Rubeola | 185 | 212 | 7 | Floyd, Howard, Polk, Pottawattamie |
| Roseola | 1 | 3 | | Scott |
| Salmonellosis | 15 | 46 | 41 | Scattered |
| Scabies | 42 | 136 | 31 | Clayton, Johnson, Polk, Wapello |
| Shigellosis | 8 | 24 | 28 | Mahaska, Polk, Scott |
| Streptococcal infections | 1498 | 3818 | 3996 | Allamakee, Dubuque, Jackson, Johnson |
| Trichuriasis | 1 | 1 | | Decatur |
| Tuberculosis, total ill | 6 | 16 | | Clayton, Dubuque, Hamilton, Warren |
| Tuberculosis, sputum pos. | 2 | 8 | | Clayton, Hamilton |
| Venereal Diseases: | | | | |
| Gonorrhea | 584 | 1457 | 1548 | Black Hawk, Linn, Polk, Scott |
| Syphilis | 34 | 74 | 111 | Scattered |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | | | |
|---|---|---|---|---|---|
| Coxsackie B5 | 2 | Eaton's agent | 2 | Herpes simplex | 14 |
| Cytomegalovirus | 4 | Enteropathogenic *E. Coli* | 3 | Herpes zoster | 3 |

# IOWA Medical Miscellany

**UR REGS . . .** Imposition of new utilization review regulation by HEW has been delayed at least until July 1. These regulations were first scheduled to be in effect February 1. AMA has filed suit against the government over the legality of the regulations. This suit is still in process.

**PROFESSIONAL LIABILITY . . .** Efforts continue in this area. An important survey was sent April 8 to all IMS members requesting information on coverage limits as well as premium and claim experience. Information is needed in consideration of "captive agency" approach directly involving Society. Medicolegal Committee met April 17 to consider legislative developments, JUA proposal of Insurance Commissioner Huff, St. Paul claims-made concept, etc.

**CPT . . .** Among items considered by Blue Shield Medical Advisory Committee at an April meeting was the AMA/CPT and ways and means of precoding claims. Efforts to iron out wrinkles in use of the AMA/CPT are being made.

**DEDICATE CENTER . . .** New $682,000 Cardiac Clinic in the U. of I. Pediatric Cardiovascular Center was dedicated in April. Facilities include six diagnostic laboratories, a reception area, physicians' offices and a conference room. The Center is affiliated with both Broadlawns and Blank Memorial Hospitals in Des Moines and serves Iowa children through a link with State Services for Crippled Children.

**AMA ASSESSMFNT . . .** Iowa is one of 11 states running above 60% in number of physicians paying the $60 dues assessment authorized by the 1974 House of Delegates.

**SEE CONGRESSMEN . . .** Society and IMPAC representatives will be in Washington, D. C., May 6 and 7 to discuss key health measures with Iowa's senators and representatives.

**EVP CHANGE . . .** Health considerations have caused Donald L. Taylor, IMS Executive Vice President, to relinquish the top administrative post he has held for more than 20 years. Action of the IMS Board of Trustees in assigning Mr. Taylor an Executive Advisor designation was announced at the House of Delegates' session. Eldon Huston, Assistant Executive Vice President of the Society and an IMS staff member for 17 years, has been named EVP.

**FAMILY PRACTICE . . .** Representatives of the Society, U. of I. and Academy of Family Physicians appeared before the joint Appropriations Committee April 8 to offer strong support for the proposed $2.9 million allocation to the Iowa Family Practice Program.

**CORRECTIONAL INSTITUTIONS . . .** Survey of medical care in county and municipal jails indicates most such care is secured on a need basis through arrangements with local physicians and hospitals. The survey was basis for report submitted to the House of Delegates by the IMS Committee on Health Care in Correctional Institutions.

**LEGISLATIVE ITEM . . .** Bill to alter current statutes relating to contractual arrangements between hospitals and physician specialists in pathology and radiology has been introduced. The bill (S.F. 439) will be watched closely by IMS legislative representatives.

**NHI . . .** Congressional hearings on NHI may begin in May under the banner of the health subcommittee of the House Ways and Means Committee.

**LEGISLATION . . .** IMS Committee on Legislation met April 23 to review status of various health proposals and determine strategy for balance of this session of the Iowa General Assembly.

SCIENTIFIC ARTICLES

# Malaria in Iowa

*Malaria remains a public health problem in parts of the world. Clinicians in nonendemic areas must be alert to possibility of encountering malaria patients.*

ABNER B. PREACHER, M.D., and
ROBIN D. POWELL, M.D.,
Iowa City

THIS REPORT will summarize experience with malaria in Iowa the last seven years and discuss practical clinical points important in the diagnosis or treatment of malaria. Although no longer endemic in Iowa or in the United States, malaria remains a formidable problem elsewhere. Persons infected in malarious areas may travel to Iowa or other nonendemic areas before symptoms begin. For this reason, it is important for Iowa physicians to remain alert to the possibility of malaria.

In the last half of the 1960's, malaria problems among American military personnel in Southeast Asia included serious difficulties with drug-resistant malaria parasites. This caused a resurgence of interest in malaria in this country. Now, the reduction in American involvement in Southeast Asia has reduced malaria-associated problems and has diminished the interest and familiarity of the U. S. medical community. It may be difficult to maintain the clinical vigilance required for prompt diagnosis and treatment of malaria.

Hundreds of thousands of Americans—including tourists, businessmen, students, Peace Corps workers and others—travel to and from malarious areas each year. Although headway has been made toward achieving world-wide eradication of malaria, the progress has slowed considerably in recent years. Contrary to early optimistic predictions that global malaria eradication would be achieved soon, it is evident it will be a major public health problem in parts of the world for many years. In view of extensive and rapid travel by civilians to and from malarious areas, we can ill afford to forget about malaria.

## BACKGROUND

The 4 species of malaria parasites long known to cause human malaria are *Plasmodium falciparum* (the cause of falciparum or malignant tertian malaria), *P. vivax* (the cause of vivax or benign tertian malaria), *P. malariae* (the cause of quartan malaria), and *P. ovale* (the cause of ovale malaria). Since infections with *P. falciparum* or *P. vivax* are considerably more common than are infections with *P. malariae* or *P. ovale*, this discussion will focus primarily on falciparum malaria and vivax malaria.

Symptoms and signs of malaria relate primarily

The authors are associated with the Department of Internal Medicine of the University of Iowa College of Medicine and the Iowa City Veterans Administration Hospital.

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to asexual erythrocytic forms of the parasite. Asexual erythrocytic forms of *P. vivax,* as well as those of *P. ovale,* develop chiefly in reticulocytes. Those of *P. malariae* develop mainly in old circulating red cells. In infections with these species, levels of parasitemia seldom exceed 40,000 to 50,000 per cu mm (about 1% of the circulating red cells). Although acute attacks may be severe, serious or life-threatening complications are relatively infrequent in vivax, ovale, or quartan malaria.

Asexual erythrocytic forms of *P. falciparum* develop in circulating red cells regardless of the age of the red cell. In falciparum malaria, a high percentage of the circulating red cells may become parasitized, overwhelming parasitemia may occur, and, in nonimmune persons in particular, there may be a high risk of serious complications, including death.

Some erythrocytic parasites differentiate into gametocytes, which cause no symptoms but are infective for mosquitoes. Gametocytes of *P. vivax, P. malariae,* and *P. ovale* are relatively short-lived. Falciparum gametocytes, on the other hand, may persist in the circulation, and may remain infective for mosquitoes, for several weeks. Vivax gametocytes often are evident within several days after asexual erythrocytic forms of *P. vivax* are first apparent in blood smears. In contrast, falciparum gametocytes usually do not become evident until at least 8 to 10 days after asexual erythrocytic forms of *P. falciparum* are first detected.

In mosquito-induced infections with *P. vivax,* persisting tissue forms of the parasite may occur and may give rise to delayed initial attacks or to relapses as parasites are released from the tissues into the bloodstream. Such delayed initial attacks or relapses of vivax malaria may occur many weeks or months after a patient leaves a malarious area. Persisting tissue forms apparently do not occur in mosquito-induced infections with *P. falciparum.*

Complete or radical cure of falciparum malaria hinges on total elimination of asexual erythrocytic parasites. If chemotherapy results in the destruction of many but not all asexual erythrocytic forms, symptoms may temporarily subside and levels of asexual parasitemia may decrease markedly, but recrudescences of falciparum malaria may occur several days to several weeks later because of a failure to eradicate all of the asexual erythrocytic parasites. In patients with mosquito-induced vivax malaria, radical cure hinges on complete elimination not only of asexual erythrocytic parasites, but also of persisting or secondary tissue forms. If chemotherapy results in the destruction of all asexual erythrocytic parasites but fails to eliminate tissue forms, relapses of vivax malaria may occur several weeks to several months later.

## IOWA MALARIA, 1966-1972

Information provided by the State Hygienic Laboratory indicates that 177 cases of malaria in Iowa were reported from 1966 through 1972 (Figure 1). One patient, a physician's wife who developed overt malaria after returning from Africa, had quartan *(P. malariae)* malaria. The other cases involved 142 episodes of overt vivax malaria in 126 different patients and 34 episodes of overt falciparum malaria in 27 different patients. These episodes, therefore, probably involved relapses of vivax malaria in at least 16 instances and recrudescences of falciparum malaria in at least 7 instances.

Seventy-nine of the cases of overt malaria in Iowa from 1966 through 1972 involved instances in which patients were hospitalized at the Iowa City VA Hospital (Figure 2). At the Iowa City VA Hospital, as was true in the state as a whole, vivax malaria was encountered far more often than was falciparum malaria. The number of cases of malaria per year increased during 1966-1968, reached a peak during 1970-1971, and then declined sharply in 1972 (Figures 1 and 2).

No deaths occurred in malaria patients treated at the Iowa City VA Hospital or in cases reported elsewhere in the state during this period. Multiple serious complications—including severe pulmonary edema, massive hemolysis, gross hematuria, marked proteinuria with anasarca, pseudomonas pneumonia, cardiac dysrhythmias, and gastrointestinal hemorrhage—occurred in 1 patient with falciparum malaria who was treated at the Iowa City VA Hospital. This patient, in whom parasitemia exceeded 2 million per cu mm on admission, survived and recovered completely in spite of a stormy clinical course.

## CLINICAL MANIFESTATIONS & COMPLICATIONS

Symptoms and signs of malaria are nonspecific. Headache, especially periorbital headache, is by far the most bothersome early symptom. Although symptoms may begin abruptly with the sudden onset of spiking fever, severe headaches,

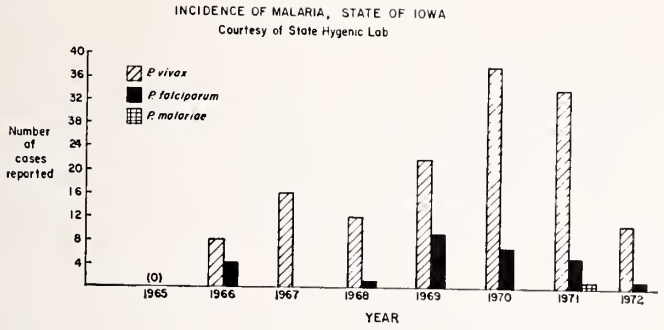


Figure 1

chills, sweats, or other manifestations, prodromal symptoms—including myalgia, malaise, slight fever, mild headache, or decreased appetite—usually precede the onset of acute attacks by from 1 to several days. As acute attacks develop, gastrointestinal symptoms—including anorexia, nausea, vomiting, and abdominal pain—are often prominent. If malaria is not among the diagnostic possibilities strongly considered, symptoms not infrequently are initially ascribed to some other type of infection, particularly an acute viral infection.

Early during the clinical course, acute attacks of malaria frequently do *not* display a classical tertian or every-other-day periodicity, splenomegaly often is *not* detectable, the hematocrit often is normal (or slightly increased because of dehydration), leukocyte counts usually are normal or low, and platelet counts may be decreased. Normal or low leukocyte counts may reinforce a suspicion that an acute viral infection is present.

As symptoms continue over several days, fever often is remittent rather than intermittent, gastrointestinal symptoms frequently increase, splenomegaly often becomes evident, jaundice may develop, and the hematocrit tends to decrease. The degree of anemia and the rapidity with which it develops vary considerably from patient to patient. Sudden and severe anemia is especially apt to occur in patients with falciparum malaria who develop high levels of parasitemia.

Other complications of falciparum malaria include disseminated intravascular coagulation (DIC), neurological complications, renal problems, and pulmonary edema. DIC is manifest by thrombocytopenia, low fibrinogen, elevated fibrin split products, and elevated prothrombin or partial thromboplastin times; decreases in certain coagulation factors, notably V, VII, VIII, and X, may occur and may contribute to diffuse hemorrhage.[1]

Neurological complications of falciparum malaria include: acute mental syndromes with confusion, disorientation, intellectual deterioration, or hostility; disorders of consciousness with lethargy, stupor, or coma; focal neurological signs such as hemiparesis; and acute personality changes.[2]

Blackwater fever is a dramatic, well publicized complication of falciparum malaria that involves massive hemolysis with hemoglobinuria. Indeed, the urine may turn dark red to black. Acute renal failure may occur in acute falciparum malaria and may or may not be associated with overt hemolysis and hemoglobinuria.

Mild proteinuria is frequent and may continue for several months after recovery from malaria. Marked proteinuria with the nephrotic syndrome, although classically associated with quartan malaria, occurs in some patients with acute falciparum malaria.[3]

A rare but almost uniformly fatal complication of falciparum malaria is pulmonary edema. Clinically, the patient, although apparently doing well, may suddenly develop marked dyspnea with hypoxemia. The chest x-ray may disclose almost total opacification of both lung fields, with changes more severe than those usually noted in patients with pulmonary edema due to cardiac failure.[4, 5]

Any of a wide variety of other complications—including rupture of the spleen, peptic ulcer with perforation or hemorrhage, bacterial pneumonia, overhydration, dehydration, a reduced effective plasma volume, postural hypotension with vertigo, cardiac dysrhythmias, or a sudden cerebrovascular accident—may occur. Although most often associated with falciparum malaria, serious complications are at times associated with other types of malaria.

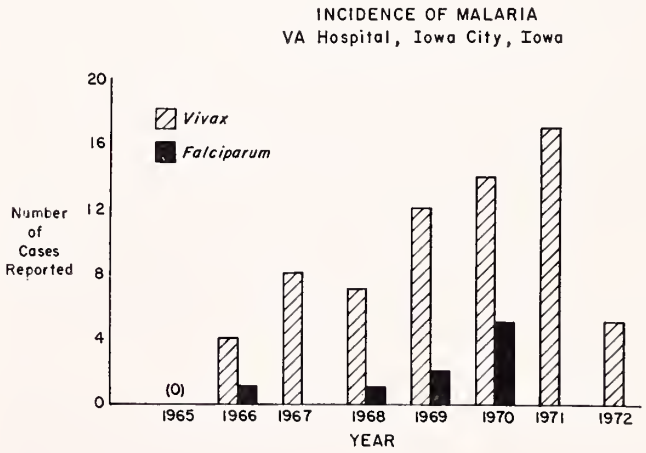


Figure 2

The early clinical course may be deceptive. For example, although vivax malaria is often referred to as benign tertian malaria, acute attacks of vivax malaria in nonimmune persons may be quite severe. In patients with falciparum malaria, acute attacks may remain relatively mild for several days and the clinical situation may then abruptly and unexpectedly deteriorate, so that a patient who appears only mildly or moderately ill one hour may be very ill several hours later.

## DIAGNOSIS

Early diagnosis and prompt institution of appropriate chemotherapy are critically important, particularly in nonimmune patients with falciparum malaria. In such patients, even slight diagnostic or therapeutic delays may have tragic consequences. Although certain symptoms or signs may strongly suggest malaria, identification of malaria parasites on microscopic examination provides the only definitive means for establishing the diagnosis.

Three keys to early diagnosis are: prompt suspicion of the possibility of malaria; prompt examination of stained blood smears for malaria parasites; and repeat examination of blood smears if initial smears are negative. Some nonimmune persons develop symptoms before asexual erythrocytic parasites are sufficiently numerous to result in positive smears. Because of wide fluctuations in levels of parasitemia, blood smears may be intermittently negative early during the clinical course of falciparum malaria. One or two negative smears do not provide evidence adequate to exclude malaria.

If symptoms develop within 1 or 2 months after a patient returns from an area where falciparum malaria is endemic, although another species may be responsible, one should be particularly concerned about the possibility of a falciparum infection. In such instances, if possible, blood smears should be prepared and examined immediately. If initial smears are negative, it may be appropriate to examine follow-up smears at relatively frequent intervals (for example, every 6 to 8 hours) over the next several days to determine whether smears remain negative and to establish the diagnosis as soon as possible if malaria is present.

If more than 3 months elapse after a patient returns from a malarious area before symptoms begin, although another species may be responsible, the species is apt to be *P. vivax*. In such instances, if initial smears are negative, it may be appropriate to examine follow-up smears at least once a day for 3 or 4 days before concluding that symptoms probably are not due to malaria.

In malaria patients admitted to the Iowa City VA Hospital during 1969-1972, intervals between the time of departure from a malarious area and the onset of symptoms of malaria ranged from 1 to 365 days in patients with vivax malaria and from 1 to 35 days in patients with falciparum malaria. The average interval in patients with vivax malaria was 115 days. That in patients with falciparum malaria was 15 days.

In general, if initial smears are negative and symptoms are due to malaria, follow-up smears will be positive within 2 to 3 days. This, however, is not always the case. In the patient with quartan malaria noted previously, acute attacks persisted and thick and thin smears, examined 3 to 4 times a day, remained negative for 6 days before a single malaria parasite was first detected.

In some patients, fever and other symptoms may reflect the simultaneous occurrence of malaria and some other disorder, particularly some other infection. The detection of the concomitant problem, such as a streptococcal pharyngitis, a bacterial pneumonia, a urinary tract infection, or viral hepatitis, may divert attention away from the possibility of malaria, especially if examination of an initial blood smear for malaria parasites is reported to be negative. In such patients, unless early follow-up smears are examined, an unfortunate delay of several days to several weeks may occur before the diagnosis of malaria is established after the possibility of malaria is reconsidered because of a persistence or recurrence of symptoms.

Malaria patients in whom symptoms are initially ascribed to some other infection not infrequently are treated with antibiotics such as tetracycline. In some patients with falciparum malaria, a short course of tetracycline may cause a transient decrease in parasitemia and a temporary abatement of symptoms, followed by a recrudescence. An initially favorable clinical response to tetracycline, therefore, does not exclude the possibility of falciparum malaria.

Such treatment with antibiotics represents one of many factors that may contribute to unfortunate delays in the diagnosis of malaria, not only in patients with falciparum infections but also in patients with vivax infections. In patients with vivax malaria admitted to the Iowa City VA

Hospital during 1969-1972 and who previously had been thought to have some other type of infection for which antibiotics had been prescribed, from 6 to 42 days elapsed after the onset of symptoms before a diagnosis of malaria was established; the average interval was 14 days.

Accurate identification of the species is of major importance, particularly in terms of chemotherapy. If the species is not accurately identified, the antimalarial agent or agents used may not be the drug or drugs of choice for the particular species involved. Some patients have mixed infections with more than one species—for example, *P. falciparum* and *P. vivax*. In patients infected with both *P. falciparum* and *P. vivax*, a delayed initial attack of vivax malaria may occur after one or more previous attacks of falciparum malaria. Unless close attention is paid to the species, the attack of vivax malaria may be misinterpreted as a recrudescence of the prior falciparum infection.

Those experienced in the identification of malaria parasites in blood smears often prefer to examine thick smears rather than thin smears. Artifacts, however, pose more of a problem in thick smears than in thin smears. Those not experienced in examination of blood smears for malaria parasites may prefer to emphasize careful examination of thin smears (smears comparable to those prepared for differential leukocyte counts). Although Giemsa stain is often preferred, smears stained with Wright's stain usually are satisfactory. The quality of the smear is more important than whether Wright's stain or Giemsa is used. It may be helpful, at the outset of examination of a particular smear, to note the characteristics of extracellular debris, artifacts, and platelets in that smear, so that artifacts and platelets or debris superimposed on red cells will be less likely to be misinterpreted as malaria parasites.

If parasites are numerous and if they include either relatively mature asexual forms or gametocytes, the detection of malaria parasites and accurate identification of the species usually pose no particular difficulties. Very good illustrations of different forms and species of malaria parasites in parasitology textbooks or other sources available in most laboratories may be of considerable help in identifying the species in instances in which observers are not well versed in examination of blood smears for malaria parasites.

A key aspect is the ability to determine if the species is a) *P. falciparum* or b) something else. The detection of distinctive crescent-shaped falciparum gametocytes or the identification of non-crescent-shaped gametocytes of other species may be of considerable help in this regard. Gametocytes may not be present, however, and identification of the species may hinge on characteristics relating to asexual forms of the parasite.

In general, asexual forms of *P. falciparum* evident in blood smears consist mainly or entirely of ring forms (with a diameter, for example, one-fourth to one-third that of the red cell). Red cells that contain older or more mature asexual falciparum parasites tend to adhere to walls of small blood vessels deep in the circulation. In contrast, asexual parasites in smears of blood from patients with vivax, ovale, or quartan malaria often include not only ring forms but also older or larger forms (with a diameter, or size, for example, greater than half that of the red cell). Older asexual forms of *P. vivax* often have an ameboid appearance with strands or filaments of the cytoplasm of the parasite spread out through the red cell. Those of *P. ovale* or *P. malariae* tend to appear more compact with conspicuous formation of pigment. Since vivax and ovale parasites develop preferentially in reticulocytes, red cells that contain parasites of these species often are relatively large; some red cells that contain ovale parasites display an oval shape. As vivax or ovale parasites mature, reddish Schuffner's dots often become evident in the cytoplasm of the parasitized red cells. Schuffner's dots are not a characteristic of red cells that contain falciparum parasites.

If the parasitized red cells are relatively large, if asexual parasites more mature than ring forms are present, and if Schuffner's dots are evident, it is reasonable to conclude that the species is not *P. falciparum*. If parasites are numerous (for example, more than 10 to 15 parasites per leukocyte so that levels of parasitemia probably exceed 40,000 to 50,000 per cu mm) and if they consist mainly or entirely of a monotonous array of ring forms, it is reasonable to conclude that the species is probably *P. falciparum*.

If parasites are sparse and consist only of young ring forms, it may be impossible to be certain about the species. Examination of follow-up smears prepared at several-hour intervals may be required to clarify the situation. In general, if falciparum malaria is a possibility and malaria

*(Please turn to page 186)*

# Lithium Use in Manic-Depressive Illness: Practical Aspects

*Treatment and prevention of Manic-Depressive Illness is enhanced by use of lithium carbonate. Of vital importance, says the author, is the proper monitoring of the serum level.*

MICHAEL J. TAYLOR, M.D.
Stockton, California

In April, 1970, lithium carbonate was released for use in the treatment of mania. Since that time, lithium has been demonstrated to be an extremely valuable therapeutic agent, not only in the treatment of patients with mania, but as a prophylactic agent; and the popularity of lithium as a therapeutic modality has dramatically increased. It is the purpose of this paper to describe briefly the indications for the use of lithium; the management of the acutely ill person with lithium; and the management of the patient taking maintenance (prophylactic) lithium so that, hopefully, physicians throughout Iowa may benefit from the considerable experience with lithium at Psychopathic Hospital.

## INDICATIONS FOR USE

It has been clearly demonstrated that lithium is effective in the prevention of the manic episodes of Manic-Depressive Illness. When manic episodes do occur in a patient taking lithium, the episodes occur less frequently and are less severe when they do occur. Lithium has also been demonstrated to be as effective as chlorpromazine in treating an acute manic episode, although the effect of chlorpromazine is more rapid in onset. Some authors feel that lithium is effective in treating the manic-like behavior in patients with Schizo-Affective Disorder; and many feel that any patient with an illness that has an episodic course and a predominance of affective symptoms deserves a trial of maintenance (prophylactic) lithium. The effectiveness of lithium in the prevention of recurrent depressive episodes is now fairly well accepted and it has recently been the practice at Psychopathic Hospital to treat such a patient with maintenance lithium. The current literature is replete with papers studying the effects of lithium in patients demonstrating great lability of affect, excessive aggressive and/or violent behavior, or other states where increased activity level or mood changes are prevalent.

## SERUM LITHIUM DETERMINATIONS

Whenever lithium is used, if it is to be effective and safe, an absolute prerequisite is the availability of a laboratory capable of doing serum lithium level determinations. The proper dosage of lithium is determined by the serum level of the ion. It is generally accepted that the minimum serum level of the ion to be therapeutically effective is 0.8 mEq/L. The upper limit of safe therapeutic serum levels is 1.2-1.5 mEq/L. Above a serum level of 1.5 mEq/L, one encounters a much greater frequency of the signs and symptoms of lithium toxicity. Whenever lithium is used, then, the clinician should prescribe whatever dose is necessary to maintain therapeutic serum levels (0.8-1.2 mEq/L). This dose will vary greatly from patient to patient and depending upon, apparently, which phase of which illness one is treating. Before discussing the more specific applications of lithium in the various illnesses described above, it is important to eliminate one of the most irritating variables in the management of a patient taking lithium—the proper and consistent timing of the serum lithium determinations.

This paper was prepared by Dr. Taylor during his residency in the Department of Psychiatry at the University of Iowa College of Medicine. Dr. Taylor is currently an Instructor, Department of Psychiatry, University of California, Davis; and Senior Psychiatrist, San Joaquin County Mental Health Services.

Because of the importance of maintaining therapeutic blood levels, it is important that the clinician have an accurate assessment of the serum level. This is best accomplished by having the blood drawn in the morning before the patient has eaten breakfast, and more importantly, before he has taken his morning dose of lithium. The patient should have taken his regular dose of lithuim the day prior to the determination. To attempt to adjust the dose of lithium according to serum levels obtained under conditions other than those described above is generally futile and meaningless. The dose of lithium required to maintain therapeutic levels varies greatly, and this will be discussed in more detail below.

## ACUTE MANIA

When dealing with an acutely-ill manic patient, the clinicians' first task is usually to control the patient's behavior by using one of the major tranquilizers (Chlorpromazine, Haloperidol) so that the patient is getting an adequate amount of sleep; is eating fairly regularly; and, most importantly before lithium is started, is taking in adequate fluids (1.5-2.0 Liters/24 hrs.). The patient may be started on low to moderate doses of lithium (900-1800 mg/day) in three or four divided doses. The serum level should be monitored every two-three days to avoid toxicity and to make certain that therapeutic levels are obtained. Doses of up to 2700 mg/day may be required in the severely ill patient. One often sees the serum level rise sharply as the mania "breaks," requiring a decrease of the dose of lithium. For example, a patient who requires 2100 mg of lithium per day to maintain a serum level of 1.0 mEq/L while acutely psychotic may require only 1200 mg/day to maintain the same serum level once the manic episode has ended.

After the psychotic episode has ended and the major tranquilizer has been discontinued, it is necessary to check the serum lithium levels approximately once/week for 3-4 weeks to make sure that the dose of maintenance lithium (usually 900-1800 mg/day) is adequate to maintain therapeutic serum levels. Once the serum level has stabilized, the level should be checked once/month for 2-3 months before one is satisfied to monitor the serum level once every 3-6 months.

It is important to stress that there is no such thing as a "little bit of lithium." One should not attempt to taper the lithium dose. If lithium is to be used effectively, it should be used at a dose to maintain therapeutically effective serum levels, or not used at all. This holds true whether one is treating an acutely psychotic patient in a hospital, or an out-patient with a history of recurrent episodes of affective illness.

## PROPHYLACTIC LITHIUM

Maintenance (prophylactic) lithium therapy can be easily instituted without having to hospitalize the patient. Assuming that there are no contraindications (see below) and that the patient is reliable enough to follow through with the physician's instructions regarding having his blood drawn under the proper circumstances, the patient can be started on lithium carbonate 300 mg three times/day and followed with weekly lithium determinations until that dose is established which will maintain a serum level of 0.8-1.2 mEq/L.

The question of how much lithium to prescribe is answered for the physician by the serum lithium level. Aside from the obvious prerequisites of patient reliability and cooperation, deciding which patients should receive maintenance (prophylactic) lithium and for how long is a more difficult question to answer. There is some information available which can assist the physician and the patient in making the decision about maintenance lithium. At the time of the first manic attack, the probability of a recurrence is less than 50%. With each subsequent manic episode, the probability of yet another recurrence increases significantly. It has also been demonstrated that an early age of onset of mania forebodes a greater probability of recurrence; more so, even, than can be accounted for by the greater time at risk. The physician can make some judgment as to the likelihood of a recurrence and thus the necessity for prophylaxis, and the patient must ask himself, "Are these episodes of my illness so disruptive to my life that I would be willing to go to the inconvenience and expense of taking lithium in hopes of preventing or at least moderating future recurrences?" The same general question must be faced by the physician and patient with recurrent depressive episodes.

## TOXICITY, CONTRAINDICATIONS

A not-uncommon complaint of patients first started on lithium is nausea or gastric irritation. This may occur at relatively low doses and is not necessarily a sign of lithium toxicity. Lithium seems to have a direct irritating effect on the gastric mucosa and the initial nausea may be dealt with by instructing the patient to take his lithium

with his meals (assuming that there are no other signs of toxicity and that the serum level is within therapeutic range). One often finds that starting at a lower dose and then gradually increasing to therapeutic dose will eliminate the nausea, if taking the medication with meals does not.

The signs and symptoms of lithium toxicity include nausea, vomiting, diarrhea, fatigue, muscle weakness, tremor, and even coma and/or grand mal convulsions. In any patient who develops symptoms of lithium toxicity, the drug should be discontinued entirely for 2-3 days and then restarted at a lower dose with frequent monitoring of serum levels.

Lithium therapy is felt to be contraindicated in patients with significant heart or kidney disease. As a general rule, the use of lithium concomitantly with diuretics should be avoided because of the interaction of the lithium and sodium ions. Thyroid function should be monitored periodically because of the possibility of patients on long-term lithium developing goiter. An electrocardiogram, and serum BUN, creatinine, and $T_4$ determinations should be done before lithium therapy is instituted. The safety and/or hazards of the use of lithium in pregnancy are yet to be firmly established. Thus, lithium should be used in pregnancy only if the patient has demonstrated a consistent pattern of severe remission with discontinuation of lithium therapy; if the patient has historically demonstrated a better response to lithium than to other therapeutic modalities (major tranquilizers, ECT) during an acute manic episode; or if other therapeutic modalities have failed to treat an on-going manic episode which could, itself, be fatal to the mother and/or fetus.

## SUMMARY

In properly diagnosed patients, lithium carbonate can be an extremely valuable medication in both the treatment and prevention of episodes of illness in Manic-Depressive Illness. Of vital importance is the proper monitoring of serum levels and the maintenance of the serum level at between 0.8 and 1.2 mEq/L if the drug is to be therapeutically effective.

## ACKNOWLEDGMENT

The author is grateful to Ming T. Tsuang, M.D., Ph.D., associate professor of psychiatry, for providing the impetus for this paper and for the guidance that he provided in its preparation.

References and/or further information will be provided by the author upon request.

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# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## "HOUSTON, WE'VE GOTTA PROBLEM"

In April 1970, a voice came down from one of our lunar space ships indicating a problem. Planning and training averted disaster, though the primary mission (as originally planned) was not accomplished.

We of the medical profession must calmly but firmly cry out to Houston, Washington, D. C., New York City, or Los Angeles: "We've gotta problem." Our problem is what to do about professional liability insurance and the rising incidence of lawsuits. Has medical practice become so bad that these lawsuits are truly valid or has society so changed that such action represents freedom to anyone who so desires can convene a jury? Do insurance companies have untold millions of dollars they can easily share with any person who feels compelled to sue?

Medical liability is becoming a plague, and court decisions are fostering the epidemic. The physician has been placed in the position of being a guarantor of the health of their patients. The doctrine of *ris ipsa loquitor* is based on a theory that if a medical result is unsatisfactory the physician is presumed to have been negligent. That would seem to be an example of the invalid *post hoc ergo hoc* logic. But, maybe justice does not have to be logical.

What of other court decisions? The locality rule is of less consequence now. A physician was once judged by the standards of medical care in the area where he resided and practiced medicine. Now he must adhere to standards that may hold in a large, academic-type institution. It places the practicing physician in a totally defensive position, requiring more extensive diagnostic workup, all at higher and higher costs to the patient. Furthermore, because of the astronomic compensations awarded in the courts, the premium for professional liability insurance has reached heights beyond previous imagination. The patients have to pay that ultimately as well.

The AMA Board of Trustees has described the deteriorating medical liability situation as the "most critical issue facing American physicans and their patients." The liability problem is causing a great bulk of the rising costs of health care, and at the same time threatening the quality and the availability of that care. New avenues of insurance coverage must be explored. A long hard look must be focused upon legal trends which have an impact on malpractice legislation, e.g., informed consent, the abandonment of local care standards, ceiling on excessive amount of damages awarded by some juries, etc.

In the meantime, physicians would be well advised to keep accurate records, refrain from volunteering information especially in writing, explain everything thoroughly to patients and document this in the patient's records, and refrain from discussing other physicians actions in front of patients.

We are out in space. Our ship is in trouble, but our training and knowledge should aid us in our tremendous calling to render health care. There have been crises before, and others shall follow. I cannot believe the legal profession, the legislative bodies, and the public as a whole can destroy our profession. We may have to cry out for help, seek consultation, and change some of our ways, but ours shall continue to be a noble profession, continuing to be held in high esteem by our patients as well as ourselves.—M.E.A.

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## BROWNIE POINTS

The Iowa legislature is now considering a bill which would lead the State Board of Medical Examiners to establish continuing education requirements as a condition of re-licensure. Many other states are considering similar legislation. It seems likely that any such requirement will be based upon accumulation of hours spent in educational endeavors of diverse kinds. I've heard some practitioners and some persons in positions of educational leadership refer to such hours of educational endeavor as "brownie points."

The phrase bugs me. In moments of tranquil reflection, I wonder why. Perhaps because I sense a gratuitous insult lurking in the words, or the context of their use. It seems that those who use the phrase are suggesting that most practitioners are engaged in a sort of fraud—that they enroll or attend meetings or conferences, or engage in private study using printed or non-print learning materials, or take self-assessment tests, or serve as teachers to students of varying types and levels, all with the sole aim of accumulating the credit hours to "lord it over" one's colleagues, or stave off the onslaught of some voracious doctor-eating bureaucracy that can be mollified only by holding before it a plaque that reads "Don't bother me—I'm one of the good guys—I have my hours."

Such a view overlooks three important characteristics of physicians: 1) They are students emotionally and gain satisfaction from learning; 2) They have great pride and want to do their work well; 3) They have strong humanitarian feelings, wanting to help their patients as much as possible, and recognize that their best service is dependent on competent and up-to-date knowledge and skills.

Physicians gained their original admittance to medical school largely because of their *proven record of success as students,* individuals who had special talent in dealing with information and problem-solving. They had, for whatever combination of reasons, a desire and willingness to work at the process of learning. Perhaps a few did it only as a chore, but I believe that the immense majority enjoyed the processes of studying and learning, and developing further their native intellectual gifts. A few perhaps have been able to turn off entirely such an interest, but I think only a few. The sense of reward and satisfaction obtained from some 20-25 years of formal learning exercises prior to entering practice has produced people who continue to look to that kind of activity as a source of personal gratification.

Next comes the matter of pride and wanting to do well, being well-regarded by peers and patients. No reader of these words needs elaboration or persuading on this point.

Finally, the desire to be maximally helpful to patients needs no long list of arguments either. What perhaps warrants comment, especially to those individuals fond of referring to continuing education as the accumulation of brownie points, is that most practitioners recognize clearly the relation between continuing education effort and doing a better job for one's patients.

Maybe I'm expressing an undue sensitivity to a subtlety of attitude conveyed by the phrase, brownie points. To me, continuing education represents a stimulating, gratifying activity made even more pleasing because I know it helps me do a better job for my patients. If *that's* what you mean by brownie points, OK. Otherwise, beware my wrath!

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## MALARIA IN IOWA

*(Continued from page 179)*

parasites are detected but the species is uncertain, it may be appropriate to assume that the species is *P. falciparum* until proved otherwise.

### TREATMENT OF VIVAX, OVALE OR QUARTAN MALARIA*

A 4-aminoquinoline—notably chloroquine or amodiaquine—is the drug of choice for termination of acute attacks of vivax, ovale, or quartan malaria. For adults, a total of 1500 mg of chloroquine base can be given orally over 3 days (600 mg of chloroquine base initially, 300 mg 6 hours later, and 300 mg on each of the next 2 days). An alternate regimen of amodiaquine involves the oral administration of a total of 1400 mg of amodiaquine base over 3 days (600 mg of amodiaquine base initially and 400 mg on each of the next 2 days). Such regimens of chloroquine or amodiaquine should effect a relatively prompt subsidence of acute attacks (usually within 24 to 36 hours), a relatively prompt decrease in levels of asexual parasitemia (blood smears usually become negative within 3 to 4 days, except in quartan infections in which the response may be slower), and complete elimination of the asexual erythrocytic forms of these 3 species of plasmodia. Resistance of asexual erythrocytic forms of *P. vivax, P. ovale,* or *P. malariae* to these particular agents has to date not proved to be a problem.

Since vivax, ovale, or quartan gametocytes are relatively short-lived, chemotherapy aimed specifically at gametocytes usually is not required. When transmission of malaria by mosquitoes is a possibility, however, it is appropriate at the outset of treatment, particularly if gametocytes are detected, for patients to be in rooms with screens on the windows and doors, to minimize the possibility of such transmission, until at least 2 to 3 days after the initiation of treatment.

Since chloroquine or amodiaquine does not destroy persisting or secondary tissue forms, such as those of *P. vivax,* it is appropriate to administer also a 14-day course of primaquine (15 mg of primaquine base orally once a day) in an effort to eliminate tissue forms and to minimize the likelihood of a relapse of vivax or ovale malaria. Whether persisting tissue forms occur in quartan malaria, and whether such treatment with primaquine is warranted in patients with quartan malaria, is uncertain.

If vomiting or other factors preclude satisfactory oral administration of antimalarial agents to patients with vivax, ovale, or quartan malaria, parenteral treatment can be employed initially (involving, for example, intramuscular administration of 200 to 300 mg of chloroquine base, in the form of chloroquine hydrochloride, repeated, if necessary, in 6 to 8 hours) with substitution of oral treatment, to complete the course of chloroquine, as soon as practicable. Intravenous fluids may be needed to correct or avoid underhydration if oral intake or retention of fluids is inadequate. Symptomatic measures—including salicylates to ease or relieve headaches, myalgia, and fever; sponge baths with water-alcohol mixtures if fever is marked and sustained; or small doses of a phenothiazine or an antihistamine if acute attacks are very severe—may be of considerable adjunctive value.

The therapeutic regimens of chloroquine or amodiaquine noted are seldom associated with major problems in terms of adverse side-effects. The regimen of primaquine noted may cause overt hemolysis in some patients who have glucose-6-phosphate dehydrogenase (G6PD) deficiency or certain other disorders of the pentose phosphate pathway of the red cell. Although hemolysis in such patients usually is slight or moderate and usually is self-limited, severe hemolytic anemia may occur in some patients who have variants of G6PD-deficiency that are associated with an especially marked vulnerability to drug-induced hemolysis. Alertness to the possibility of such hemolysis is warranted.

Follow-up examinations of blood smears (for example, daily for several days until smears have been negative for at least 2 days) are of value in documenting that parasitemia is responding as anticipated. In patients with vivax malaria, if acute attacks do not subside within 36 to 48 hours or if blood smears remain positive for asexual parasites for more than 3 to 4 days, certain possible complicating factors—including a failure to ingest or absorb medication, a concomitant febrile disorder in addition to malaria, or a mixed infection with more than one species of plasmodia (for example, a simultaneous infection with 4-aminoquinoline-resistant *P. falciparum*)—merit careful consideration.

* Dosages of antimalarial drugs noted in this report pertain to treatment of malaria in adults. Information about treatment of malaria in children is available in a paper by Gilles (*British Medical Journal,* 2:1375-1377, 1966).

A 14-day course of primaquine should greatly reduce the likelihood of a relapse, but is not invariably effective for this purpose. If a relapse—of vivax malaria, for example—occurs despite prior treatment with a 4-aminoquinoline and primaquine, repeat administration of a 3-day course of chloroquine or amodiaquine, to terminate the acute attack, and administration of a second course of primaquine, to reduce chances of a further relapse, represent appropriate steps. In general, a failure of primaquine to prevent subsequent relapses is less likely to occur when primaquine is given during a relapse than when the drug is given during a primary attack.

### TREATMENT OF FALCIPARUM MALARIA*

Strains of *P. falciparum* resistant to 4-aminoquinolines and to certain other synthetic antimalarial agents have been encountered in parts of South America, Central America, Southeast Asia, and the Philippines. Such strains have created major chemotherapeutic difficulties. Although alleged to be present in certain parts of Africa, the existence of strains of 4-aminoquinoline-resistant *P. falciparum* in Africa has to date not been conclusively documented. Recommendations regarding the chemotherapy of infections with 4-aminoquinoline-resistant *P. falciparum* are subject to considerable difference of opinion and debate. The following comments are intended to provide flexible guidelines subject to modification as additional insight is obtained or if newer and better agents for the treatment of 4-aminoquinoline-resistant falciparum malaria become available over the next several years.[6]

In instances involving falciparum malaria acquired in areas where 4-aminoquinoline-resistant *P. falciparum* has not been documented to be present (malarious areas of Africa, for example), treatment with chloroquine or amodiaquine, as noted in the preceding section on vivax, ovale, and quartan malaria, appears appropriate. For termination of acute attacks of falciparum infections acquired in other areas, where 4-aminoquinoline-resistant strains are known to exist, quinine, although far from ideal, represents a reasonably reliable agent. Chloroquine and amodiaquine are less toxic than quinine and are superior to quinine, in terms of efficacy, against drug-sensitive strains.

Unfortunately, there currently is no quick yet uniformly reliable laboratory method for determining whether a particular patient is infected with drug-sensitive or drug-resistant parasites. Patients infected in areas where 4-aminoquinoline-resistant falciparum parasites are known to exist may or may not be infected with drug-resistant parasites. Different strains vary in the degree to which they are resistant to 4-aminoquinolines. Some strains are highly resistant to these agents. In nonimmune persons in particular, a clinical or therapeutic trial with a 4-aminoquinoline may prove hazardous. Consequently, at present, for termination of acute attacks of falciparum malaria acquired or possibly acquired in areas (such as Southeast Asia) where 4-aminoquinoline-resistant parasites are known to exist, we prefer to rely mainly on quinine even though some patients so treated may be infected with 4-aminoquinoline-sensitive parasites.

One regimen that may be used involves the oral administration of 10 grains of quinine sulfate (540 mg of quinine base) orally every 8 hours for 10 days. If parenteral therapy is necessary, quinine dihydrochloride (10 grains—diluted in normal saline, for example—by slow intravenous drip, repeated, if necessary, at 6- to 8-hour intervals, but with a total dose not exceeding 30 grains per day) can be given initially, with oral treatment substituted as soon as possible. In general, quinine should effect a subsidence of acute attacks within 4 to 5 days and a decrease in asexual parasitemia so that blood smears prove negative for asexual forms within 4 to 6 days. A more rapid favorable response often occurs in patients treated with quinine who do not have severe acute attacks and in patients treated with chloroquine or amodiaquine who are infected with drug-sensitive parasites.

Serial determinations of plasma quinine levels may help to minimize risks of severe cinchonism. A reasonable therapeutic range of plasma quinine levels to aim at is from 5 to 10 mg/liter. Downward adjustments of the dosage of quinine are warranted if plasma levels exceed this range and, in particular, in patients with renal failure. Serial follow-up examinations of blood smears—once a day, for example—are of value in assessing the response of asexual parasites. Some strains of *P. falciparum* are relatively resistant to quinine. A persistence of patent *asexual* parasitemia during the second half of a 10-day course of quinine or a recrudescence of patent asexual parasitemia within several days to several weeks after completion of a 10-day course of quinine suggests either a problem with drug ingestion or absorp-

tion or the presence of parasites that are relatively resistant to quinine.

Certain strains of *P. falciparum* that are relatively resistant to quinine display recrudescences in a high percentage of patients after 7-, 10-, or 14-day courses of quinine. To minimize the possibility of a recrudescence in patients treated with quinine, it may be reasonable to administer, in addition to quinine, 1 or more other antimalarial agents. One such regimen, for example, involves treatment with a 10-day course of quinine followed by oral administration of a combination of pyrimethamine (50 mg daily for 3 days) and sulfadiazine (500 mg every 6 hours for 5 days). In such instances, quinine serves to terminate acute attacks and to reduce levels of asexual parasitemia, and the pyrimethamine-sulfadiazine combination is of adjunctive value in efforts aimed at complete elimination of asexual erythrocytic parasites so as to prevent recrudescences. Certain other agents or combinations of agents may be as effective as, or may prove superior to, this particular sulfadiazine-pyrimethamine combination for this purpose.

If mature falciparum gametocytes are present at the outset of administration of chloroquine, amodiaquine, quinine, pyrimethamine, or sulfadiazine, they may persist and may remain infective for mosquitos during and after treatment even though asexual parasites are entirely eliminated. Follow-up smears are useful in detecting gametocytes, which may not be evident initially. A persistence of falciparum gametocytes should not be misconstrued as a failure to obtain a satisfactory response in terms of asexual parasites. Fortunately, primaquine is active against falciparum gametocytes. A single oral dose of 45 mg of primaquine base may be of value in rendering such gametocytes noninfective for mosquitoes within 1 to 2 days and in destroying falciparum gametocytes within several additional days. Precautions with respect to screening of doors and windows comparable to those noted in the previous section are warranted, particularly if falciparum gametocytes are evident in blood smears.

Nonchemotherapeutic measures to combat dehydration, overhydration, severe anemia, hypotension, shock, renal failure, cerebral edema, or other complications often are of crucial importance in patients with severe falciparum infections. The value or role of steroids in patients with severe falciparum malaria and the value or role in such patients of therapeutic agents that are at times used to combat disseminated intravascular coagulation remain to be determined.

In patients with falciparum malaria in whom the response to chemotherapy appears satisfactory, it may be wise to perform follow-up examinations of blood smears for several weeks after completion of treatment (for example, 2 or 3 times a week for 6 to 8 weeks) to try to be certain that radical cure of the infection has been achieved or to detect recrudescences as soon as possible if radical cure has not been achieved. In nonimmune persons, if asexual erythrocytic parasites have not been completely eliminated, recrudescences of symptoms and of patent parasitemia usually occur within 3 to 4 weeks after the end of treatment.

In patients who have developed substantial partial immunity, recrudescences of patent asexual parasitemia may be asymptomatic or may be associated with only minor or transient symptoms. Gametocytes in such patients may serve as a source for transmission of malaria by mosquitoes. Follow-up examinations of blood smears may be of considerable value in identifying such instances.

In nonimmune persons infected with both *P. falciparum* and *P. vivax,* overt falciparum malaria often develops first and the vivax infection usually does not become overt until after one or more attacks of falciparum malaria have occurred. In patients with falciparum malaria, therefore, the possibility of a concomitant but latent vivax infection merits consideration. Of 42 patients with vivax malaria hospitalized at the Iowa City VA Hospital during 1969-1972, 10 had had previous episodes of overt falciparum malaria for which they had been treated elsewhere. Because of the possibility of a concomitant vivax infection, it may be reasonable in patients with overt falciparum malaria to administer a 14-day course of primaquine in an effort to eliminate possible persisting tissue forms of *P. vivax* and minimize changes of a subsequent delayed initial attack of vivax malaria. Such treatment with primaquine serves also to render noninfective for mosquitoes, and eliminate, falciparum gametocytes.

## SUMMARY

A main aim of this report has been to provide a reminder: that malaria is still an important public health problem in many parts of the world;

that clinicians in nonendemic areas need to remain alert to the possibility of encountering patients with malaria; that prompt and effective chemotherapy is of crucial importance, especially in nonimmune persons with falciparum malaria; and that early diagnosis and accurate identification of the species are key factors from the standpoint of expeditious initiation of appropriate chemotherapeutic measures. Although it is necessary to use different drugs for different antimalarial purposes, and although there is a very substantial need for newer and better antimalarial agents, presently available drugs provide reasonably effective means for combatting infections in most instances.

The possibility of malaria merits serious consideration in any patient who has a febrile illness and who, in recent weeks, months, or even several years, has been exposed in a malarious area. Since malaria can be transmitted not only by mosquitoes but also by inoculation of parasitized red cells, malaria also warrants consideration in patients who develop febrile illnesses after blood transfusions and among drug users who use drugs parenterally and who share needles or syringes with others. A strong suspicion of malaria based on a history of exposure in a malarious area often is a major factor in early diagnosis. We need to be alert also to the possibility of blood-induced infections with malaria parasites, in which case a history of exposure in a malarious area usually is not present to stimulate a suspicion of malaria.

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# HSA MINUS RMP & CHP=NEW HEALTH PLANNING

PUBLIC LAW 93-641 is one of the newest federal health care statutes on the books. Its official designation is National Health Planning and Resources Development Act of 1974. Its complex dimensions and aspects will take time to understand. And it brings with it a new jargon and a new set of abbreviations.

For instance, RMP and CHP will give way now to HSA. That means Regional Medical Program and Comprehensive Health Planning will be replaced by the Health Systems Agency.

Under the new law, every state must designate a health service area or areas. Then the states must establish a Health Systems Agency or Agencies as private non-profit corporations to perform planning and development functions.

Phase One of the new law must be accomplished this month with the Governor submitting to the Secretary of Health Education and Welfare a proposal for the designation of health service area boundaries in Iowa. An eight-member advisory committee has submitted its recommendations to Governor Ray. The committee advocated either of two approaches: (1) either one statewide health service area, or (2) four regional-type health service areas.

In January, based on its early understanding of the law's requirements, the Iowa Medical Society Executive Council supported the designation of Iowa as a statewide health service area. Authorization was given for a modification in this recommendation should further study suggest the wisdom of such action.

What happens after the Governor makes his recommendation?

The HEW Regional Offices will seek to resolve any problems which arise over the relationship of state boundaries and the health service areas. By August, the Secretary of HEW is to publish the designated areas in the Federal Register.

Once the health service area is approved a non-profit corporation is to be formed to seek approval from HEW as the Health System Agency. The eventual HEW designation of the HSA or HSAs, depending on the number in a state, may be permanent or on a two-year provisional basis. HSAs for all health services areas must be approved by June 4, 1976.

When the HSA has been approved the existing Regional Medical Program (RMP), Comprehensive Health Program (CHP), Hill-Burton Program and Experimental Health Service Delivery System (EHSD) will phase out.

The Governor must designate one State agency to serve as the Health Planning and Development Agency (HPDA). This agency, which may be an existing or a new governmental entity, will perform functions which are now the responsibility of CHP and Hill-Burton units. It is permissible to designate CHP as the HPDA.

A Statewide Health Coordinating Council must be structured to advise the HPDA. The structuring of this Council tends to presume multiple Health Systems Agencies and it (1) must prepare a state health plan that incorporates individual HSA plans, (2) reviews and coordinates HSA operational plans and forwards them for HEW review, and (3) approves applications for certain Public Health Service funds.

A first requirement of an HSA will be to devise a plan for the delivery of health care in its area. Approval of this plan by HEW will be required before other assigned duties may be performed.

Tied to this emerging program is the necessity for state enactment of certificate of need legislation. Such state legislation must be enacted in less than four years or certain federal funds will be threatened. Under certificate of need legislation a hospital or other facility must secure a certificate before undertaking any expansion or change of service.

In the maze of these new federal and state mandates to plan for health services with bureaucratic efficiency, it must be remembered that health care reduces itself to the physician seeing the patient, one-to-one, and doing the best job possible.

# IN THE PUBLIC INTEREST

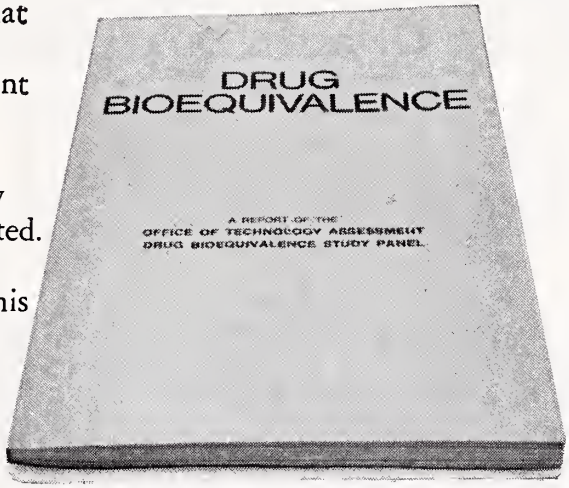
# the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.




"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A
Pharmaceutical Manufacturers Association
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*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

# protecting the integrity of your prescription

# Medical Assistants

by TENORA MEYER, CMA

## NEW PRESIDENT

Nancy Winter, Davenport, was installed as president of AAMA, State of Iowa, April 12, 1975, at the convention in Davenport. She is receptionist-secretary for Bernard R. Goldman, M.D., Davenport, and has been employed in this capacity for 17 years. Nancy has been very active in the AAMA on the local and state levels.

### PRESIDENT'S MESSAGE

It is indeed a tremendous honor for me to accept the office of President of the American Association of Medical Assistants, State of Iowa.

As I accept the gavel, I find it surprisingly heavy—and I am aware that it is heavy with responsibility. I do accept the responsibilities, knowing that there is only one way that our aims and goals can become realities, and that is by WORKING TOGETHER. Only with the complete cooperation and complete communication from the entire membership can this be accomplished.

Everybody who belongs to an organization wants it to be strong, so it can do the work it was intended to perform—but strong groups don't just happen—they come by support and work. Any organization is only as strong as the support it receives from all its members. The same self-interest that motivates members to join should keep them building together to improve and maintain a stronger and more effective organization.

I'd like to quote from one of the prophets of our day, Jonathan Livingston Seagull. "We're free to go where we wish and to be what we are."

We have at this time, more than ever before, so many opportunities available to us to improve and continue our education and to become better Professional Medical Assistants.

But, as the old saying goes, "Anything in life that is worth having—worth keeping—is worth working for." So it is up to us, the entire State of Iowa, to "press on" as individual members, all WORKING TOGETHER, to heighten and broaden the goals of our organization.

The secret of happiness is something to do! As Medical Assistants, our cause is to serve humanity. In our profession, as we serve humanity each day, we realize that happiness is not in having or being; it is in doing. As life becomes more hectic, let us always take time to meet our patients with kindness and consideration. Let us guard our image as competent, professional persons.

To me, the word DEDICATION is a very meaningful word. When you are dedicated to your job, our organization, you want to do your very best. Well, this is what AAMA is all about! Our organization provides the opportunity and the stimulation you need to serve the Medical Profession to the best of your ability.

So, it is our responsibility to reach out to other Medical Assistants and inform them how they, too, can become a Professional Medical Assistant and participate in our Chapter activities: State Workshops, Seminars, Conventions—both State and National, Guided Study Courses, and the Certification Program. At the same time, WE are increasing our Membership, and WE are strengthening our State.

Let us all GROW WITH IOWA and remember, the right time is NOW.

AAMA, State of Iowa, is now 19 years old! Yes, we are getting older—but we are getting wiser.—*Nancy L. Winter*

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# About IOWA Physicians

At March meeting of Wright County Medical Society, **Dr. Norman W. Hoover,** Mason City, spoke on the future for medical care in Viet Nam. Dr. Hoover served seven years in Viet Nam as an AMA coordinator for medical education. . . . **Dr. John F. Bacon,** Ames, has been elected to three-year term on Board of Chancellors of American College of Radiology. Dr. Bacon is past president of Rocky Mountain Radiological Society, Iowa Radiological Society, and Story County Medical Society. . . . **Dr. Adrian Wolbrink,** an orthopedist, will join Park Clinic in Mason City in June. A medical graduate of University of Minnesota, Dr. Wolbrink interned in Sioux Falls, South Dakota, and served his residency at Mayo Clinic. Following two years in Public Health Service at St. Elizabeth's Hospital in Washington, D. C., Dr. Wolbrink and his family went to Korea where he served as a Presbyterian missionary for three years. . . . **Dr. Donner Dewdney,** medical director of Orchard Place in Des Moines, was the guest speaker at Council Bluffs meeting of Iowa Schizophrenia Association. Dr. Dewdney's topic "The Schizophrenic Experience." . . . **Dr. Earle Stine, Jr.** has closed his medical practice in Ida Grove and will begin postgraduate training in nuclear diagnostic procedures at U. of I. College of Medicine in July. . . . **Drs. Frederick K. Chapler** and **Rudolph P. Galask,** associate professors of obstetrics and gynecology at U. of I., were guest speakers at one-day continuing education meeting at Guttenberg Municipal Hospital for physicians, nurses and allied health personnel.

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**Dr. Wilson C. Wolfe,** Ottumwa, is retiring from active practice due to ill health. He has practiced 35 years. . . . **Dr. Carl O. Lester,** Marshalltown, has been named a Fellow of the American Academy of Orthopaedic Surgeons. . . . **Dr. W. J. Neuzil,** retired Cedar Rapids physician, was presented a recognition plaque for services rendered Mercy Hospital 52 years ago. Dr. Neuzil, IMS life member, was first president of the Mercy Hospital medical staff serving from 1921 to 1922. . . . **Dr. Ralph L. Wicks,** Boone, IMS president, and **Dr. W. H. Verduyn,** Reinbeck, discussed doctor recruiting at recent refresher course for family practitioners at U. of I. College of Medicine. . . . **Dr. Maurice W. Van Allen,** professor and head of the Department of Neurology at U. of I. College of Medicine, was guest speaker at monthly meeting of Wapello County Medical Society. Dr. Van Allen's topic "Diagnosis and Management of Headache." . . . **Dr. Stanley I. Levine** will begin pediatrics practice in Ottumwa in June. Dr. Levine received the M.D. degree at U. of I. College of Medicine and served his residency at University Hospitals. He is currently affiliated with the Pediatric Department of the University of Rochester School of Medicine and also serves as an assistant professor of microbiology at Yale University. . . . **Dr. Dale Harding,** Eagle Grove, spoke at meeting of Hope for Hypoglycemics in Humboldt. His topic was "Hypoglycemia and Alcoholism."

---

**Dr. R. F. Coatney,** D.O., Anita, is new chief of staff at Cass County Memorial Hospital. . . . **Dr. Richard Schoonover** has retired from the staff of the Gilfillan Clinic in Bloomfield because of physical disability. . . . **Dr. William Erps** opened a medical practice in Alta in February. . . . **Dr. Montague S. Lawrence,** Cedar Rapids, was guest speaker at monthly meeting of Linn County Chapter, American Association of Medical Assistants. . . . **Dr. James Gannon** is new chief of staff at Pocahontas Community Hospital, and **Dr. James Slattery** is vice chief. Both are Pocahontas physicians. The April JOURNAL reported **Dr. Jon Blaschke** as a cardiologist planning to conduct cardiac clinics on a part time basis in Elkader. Dr. Blaschke is an internist, not a cardiologist, and will practice internal medicine in Elkader upon completion of his residency at U. of I.

## DEATHS

**Dr. Roy N. Reuber,** 79, Mason City, died March 14 at a Mason City hospital. Dr. Reuber received the M.D. degree at Loyola University Medical School and interned at St. Anne's Hospital in Chicago, Illinois. Prior to locating in Mason City in 1930, Dr. Reuber practiced medicine in Klemme and Sheffield. He was a life member of the Iowa Medical Society.

**Dr. William S. Bennett,** 93, last living graduate of Keokuk Medical College, died at his home in San Diego, California, March 19. Dr. Bennett received the M.D. degree at Keokuk Medical College in 1907. He began his practice of medicine in Bradyville, Iowa, then moved to Colorado and later located in California. He retired from medical practice in 1950.

**Dr. John Greenleaf,** 56, clinical assistant professor at U. of I. College of Medicine and chief of urology service at Veterans Hospital in Iowa City, died March 31 at his home. Dr. Greenleaf received the M.D. degree at U. of I. College of Medicine, interned at Salt Lake City, Utah and completed his residency at U. of I. He was a past president of Mercy Hospital medical staff and Johnson County Medical Society.


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# LIST YOUR WANTS

No charge is made for the ads of members, wives of deceased members of the Iowa Medical Society or physicians seeking Iowa locations; for others the cost is $1.00 per line, $5.00 minimum per insertion. Copy for ad must be received by the seventh of the month for the following issue. Send to JOURNAL OF THE IOWA MEDICAL SOCIETY, 1001 Grand, West Des Moines 50265.

**WANTED—GENERAL PRACTITIONER—to join another doctor in friendly, rural community of New Sharon, Iowa. Population 1200, 11 miles from Oskaloosa, Iowa. Serve 3-4 other small communities and large rural area. Write or call Richard E. H. Phelps, M.D., 109 North Main, New Sharon, Iowa 50207. 515/637-2621 or 515/637-2246.**

**GENERAL PRACTITIONER NEEDED: Friendly rural community. Moville, Iowa, population 1,200, 14 miles east of Sioux City, Iowa. Unlimited opportunity for a family physician. Phone 712/873-3158 or 712/873-3455.**

**WANTED—FAMILY PRACTITIONER to join 8-man multispecialty group. Excellent clinic and hospital facilities. Unusually progressive small community in which to live and raise a family. Excellent salary and benefits, partnership in twelve months, liberal vacation and meeting time. Contact Richard A. Callis, Administrator. McCrary-Rost Clinic, Lake City, Iowa 51449. Telephone 712/464-3194.**

**LOCUM TENENS NEEDED—July 3 to August 7, 1975, in rural family practice. Salary $3,500. Housing and car available. Swimming pool and tennis court within one block. Golf course one mile outside of town. Contact W. H. Verduyn, M.D. 514 Main Street, Reinbeck, Iowa 50668. Phone 319/345-6461.**

**DOCTORS . . . MINNESOTA/WISCONSIN WANTS YOU! (All Specialties)—A professional and time-saving approach to practice re-location. Over 50 choice opportunities to choose from at no cost to you. For discreet and confidential assistance, call collect, M. A. Cornwall, M.D., MMI's Medical Director, or write: Midwest Medical, Inc., Lakeland, Minnesota 55043, 612/436-5161.**

**WANTED—FAMILY PRACTITIONER—to join 8-man multispecialty group. Good progressive community, new hospital. Old established group. Liberal contract. Contact Ed Murphy, Clinic Manager, Carroll Medical Center, 502 North Court, Carroll, Iowa 51401.**

**WANTED—GP/Family Practitioner in Hartley, Iowa. Salary, $36,000 and percentage for one year. In one year, if agreed by both parties, full partnership. Gross in 1974, $250,000. Nearly new 30-bed hospital and recently built new Medical Center. Write or call I. E. Brown, M.D., Hartley, Iowa 51346. Call 712/728-2820, office, or 712/728-2765, residence.**

**INTERNIST with subspecialty interest in cardiology needed by 17-man multispecialty group in midwest community of 30,000. Competitive financial arrangements, partnership after one year, Keogh plan, 250-bed regional hospital. Write No. 1503, Journal of Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

**STUDENT HEALTH PHYSICIAN—Interest in sports medicine and routine health practice. 9,000 students. Available July 1, 1975. Salary competitive. Contact Director, Student Health, University of Northern Iowa, Cedar Falls, Iowa 50613.**

**FAMILY PRACTITIONER wanted to take over established practice with four Family Physicians in 16-man multispecialty group. Central Iowa community of 30,000. Competitive financial arrangements, many benefits, 250-bed regional hospital. Write No. 1504, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

**LOCUM TENENS WANTED—the month of October, 1975. Active rural practice, hospital in town. Salary negotiable. Contact K. A. Garber, M.D., 100 East South Street, Corydon, Iowa 50060. Telephone 515/872-2111.**

**CARDIOLOGIST, OPHTHALMOLOGIST, ORTHOPEDIC SURGEON, UROLOGIST AND FAMILY PHYSICIAN wanted to join established 17-man multispecialty group in Central Iowa. Excellent opportunity in growing, dynamic clinic with immediate financial partnership. Combined regional hospital, excellent schools, recreational facilities. Many benefits. Write No. 1505, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

**LOCUM TENENS needed first ten days or two weeks in June. Salary open. Golf Course, Swimming Pool, Tennis Courts. For further information write No. 1506, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

**MEDICAL DIRECTOR—Kansas City area prepaid group medical practice in planning stages seeks Medical Director. Prefer primary care physician with experience in medical group organization and administration. Salary and hours negotiable. Write No. 1507, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

**WANTED BY GROUP of Specialists and G.P.'s in Southern Missouri town of 10,000. GP, Internist, or Ob-Gyn, under 40, willing to work hard and rotate call. Ample time off (5-day week), one week Postgraduate Study, 4 weeks vacation. Salary $36,000-$50,000. Double this amount after 2 years and become full partner. Reply to No. 1508, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

**CLARA CITY, MINNESOTA is a city of 1,500 located in the heart of Minnesota's best farming area and on the edge of the lake and recreation area. The best of two worlds is available to a doctor who desires to become a part of a three-man clinic. The finest hospital in Minnesota is close at hand. If interested, contact Dr. Milton Gaebe, 1127 Division Street N., Clara City, Minnesota 56222. Phone 612/847-3454 residence or 612/847-2111 office.**

**WANTED—Good used X-ray, 100+ MA with rotating anode, fluoroscopy, etc. Call or write Scott Linge, M.D., Fayette Medical Clinic, P. O. Box 157, Fayette, Iowa 52142. Phone 319/425-3381.**

**LOCUM TENENS NEEDED—July 3 to August 7, 1975 in rural family practice. Salary, $3,500. Housing and car available. Swimming pool and tennis court within one block. Golf course one mile outside of town. Contact W. H. Verduyn, M.D., 514 Main Street, Reinbeck, Iowa 50669. Phone 319/345-6461.**

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Burroughs Wellcome ..... 174D

Dain, Kalman & Quail ..... 193

Lilly, Eli, & Company ..... 165

McNeil Laboratories ..... 169
Medical Protective Company ..... 195
Merck, Sharp & Dohme ..... 182B, C, D

Pharmaceutical Manufacturers Association ..... 190D, 191
Prouty Company ..... 189

Robins, A. H., & Co. ..... 170A, B
Roche Laboratories .... 166-167, 174B, C, 190B, C, 199-200
Roerig, J. B., & Co. ..... 190A

Searle, G. D., & Co. ..... 182, 182A
Smith, Kline and French ..... 174A
Stockdale, Inc. ..... 195

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• **Honor Former Editors**—Page 207
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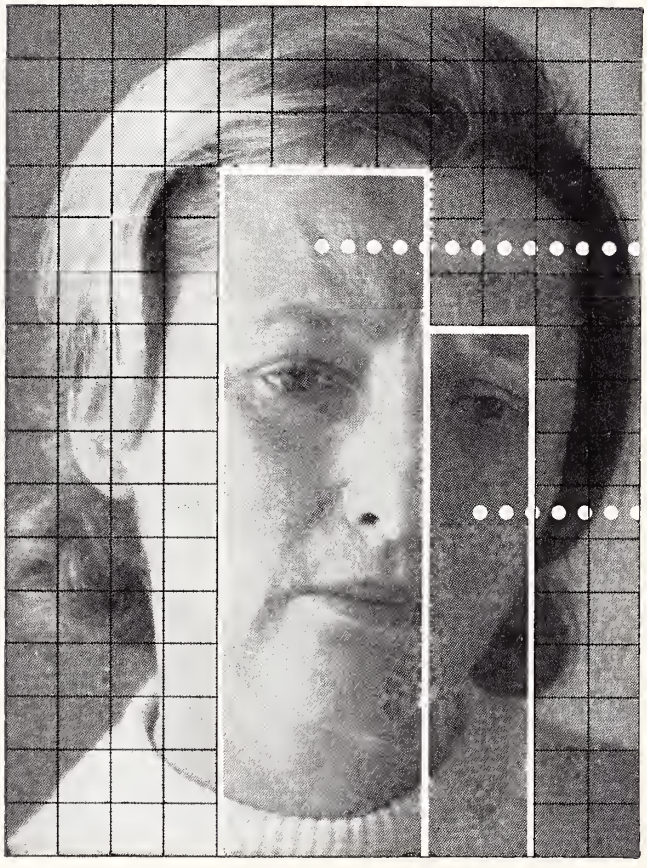
• **IFMC Gets Initial PSRO Nod**—Page 234

JUNE 1975

# Both often

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**recautions:** If combined with other psy- notropics or anticonvulsants, consider arefully pharmacology of agents em- oyed; drugs such as phenothiazines, arcotics, barbiturates, MAO inhibitors nd other antidepressants may potentiate s action. Usual precautions indicated in atients severely depressed, or with latent epression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# President's Page

The recent two-day session of the 1975 House of Delegates was a good one. The various reports and resolutions were debated actively at the reference committee hearings and finally on the floor of the House.

The streamlined schedule appeared to work well with the reference committee reports, reproduced during the night, ready for the delegates at 8 a.m. on the concluding day.

Debate occurred, and differences in thinking existed, nonetheless, it is significant that a sense of unity prevailed and was evident in the final actions. I believe the House—which is the profession's policy-making instrument—reflects the often heard remark that *in unity there is strength.*

The House commended the Medico-Legal and Legislative Committees for their efforts in the crucial medical liability area. Interest in and frustration over malpractice were abundant. In fact, I have had a number of inquiries regarding membership on the Medico-Legal Committee. Three-year terms on this committee are stipulated and there are openings for three new members this year. I regret being unable to appoint all those who expressed interest.

To reinforce one resolution approved by the House on medical liability, I urge all physicians experiencing difficulty to forward to the Insurance Commissioner, to appropriate legislators and to the Iowa Medical Society specific information on excessive premiums, non-renewal of coverage, etc.

With detailed information of this type in hand, we can develop a much more accurate focus on the problem.

**Sincerely,**

V. L. Schlaser MD

*V. L. Schlaser, President*

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# IOWA Medical Miscellany

**1975 HOUSE ACTIONS . . .** IMS News Bulletin 75-8 (5/5/75) highlighted recent House actions. Five resolutions on professional liability were approved which call for short- and long-range activity. Authorization was given to seek AMA approval for an IMS continuing medical education accreditation program. Under the program, certain local institutions obtaining IMS endorsement would be fully accredited by AMA standards. The House encouraged IMS support for passage of amendments to PSRO as suggested by the AMA; at the same time, the Iowa Foundation for Medical Care was urged to pursue PSRO designation.

**OTHER ACTIONS . . .** The House also approved the general concept of a pilot pharmacy project to be directed by Blue Cross and the Iowa Pharmacy Service Corporation; authorized publication of data on common psychotropic drugs by the Committee on Drug Abuse in the IMS JOURNAL; commended the Committee on Health Care in Correctional Institutions for completing its assessment of health care in county and city jails; urged continued efforts to build and maintain good professional communications between the College of Medicine and referring physicians; recommended candidates for IMS offices provide statements on various issues prior to annual meetings; requested the Scanlon Medical Foundation to increase its support of medical students; approved restricting customary fee data for use by the Iowa Foundation for Medical Care to preserve confidentiality and assure credibility; asked that nonparticipating physicians be provided copies, when appropriate, of Blue Shield Explanation of Benefits forms; resolved that physician-patient communications be stressed by all IMS members; and approved changes in the Articles and By-Laws to stagger terms of AMA alternate delegates.

**NEW OFFICERS . . .** V. L. Schlaser, M.D., Des Moines, became 1975-76 IMS president May 1. Elected to new offices May 1 were J. F. Bishop, M.D., Davenport, president-elect; C. D. Ellyson, M.D., Waterloo, vice-president; and Hormoz Rassekh, M.D., Council Bluffs, trustee. Re-elected were W. R. Bliss, M.D., Ames, secretary; T. A. Burcham, M.D., Des Moines, treasurer; L. D. Caraway, M.D., Amana, speaker; R. D. Whinery, M.D., Iowa City, vice-speaker; C. E. Radcliffe, M.D., Iowa City, AMA delegate; and J. M. Rhodes, M.D., Pocahontas, J. R. Anderson, M.D., Boone, and J. R. Scheibe, M.D., Bloomfield, all AMA alternate delegates. A. J. Havlik, M.D., Tama, is new chairman of the IMS Board of Trustees.

**JUDICIAL COUNCIL . . .** New District 11 councilor, to replace Dr. Rassekh, is Arthur L. Sciortino, M.D., Council Bluffs. Re-elected to the Judicial Council were D. F. Rodawig, M.D., Spirit Lake, C. H. Denser, Jr., M.D., Des Moines, and J. D. Kimball, M.D., Osceola. J. E. Tyrrell, M.D., Manchester, and D. M. Youngblade, M.D., Sioux City, are Council chairman and secretary, respectively.

**AWARDS . . .** R. F. Birge, M.D., Des Moines, received the 1975 IMS Merit Award at the April 30 Delegates' dinner. Other recognition included: Ben T. Whitaker Teaching Award—Robert C. Hardin, M.D., Iowa City; John F. Sanford Award —Paul G. Norris, Jr., Marshalltown; Washington Freeman Peck Award—Iowa Farm Bureau Federation. Special recognition was also accorded to Donovan F. Ward, M.D., Dubuque, past president of the AMA, and Donald L. Taylor, who is retiring this month as IMS executive vice president to become executive advisor.

*(Please turn to page 228)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 6
JUNE 1975

## TABLE OF CONTENTS

Vaginal Voiding: An Introduction
Richard L. Vaught, M.D. . . . . 213

A Case of Congenital Pyloric Stenosis With Hematemesis and a Strong Family History
J. C. Justin, M.D. . . . . 219

Diagnosing Tuberculosis in Children
Joanna J. Seibert, M.D., and Lee Frank, M.D. . . . . 221

Segmental Infarction of the Greater Omentum
V. B. Mulay, M.D., and H. A. Gearhart, D.O. 225

**EDITORIALS**

What Goes Up Must Come Down . . . . 227

Lousy Cities . . . . . 227

**SPECIAL DEPARTMENTS**

President's Page . . . . . 204

Iowa Medical Miscellany . . . . . 205

Question Box . . . . . 211

State Department of Health
Health Aspects of Vietnamese Immigration . . . . . 229

In the Public Interest . . . . . 234

Educationally Speaking . . . . . 236

Medical Assistants . . . . . 238

About Iowa Physicians . . . . . 239

Deaths . . . . . 243

**MISCELLANEOUS**

A Dedication . . . . . 207

We've Come A Long Way Baby . . . . 209

Iowa Medical Liability Data . . . . . 210

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# A Dedication

MARION E. ALBERTS, M.D.
Scientific Editor

IT IS WITH EXTREME PLEASURE that this June, 1975 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY is dedicated to two men who have been an inspiration to me and many others. Both are former editors of this JOURNAL. Foremost to me, however, they were my mentors in my years of training as a pediatrician. At one time they were partners in the practice of pediatrics.

Lee Forrest Hill, M.D.

Lee Forrest Hill became Editor of the JOURNAL in 1936, continuing in that capacity until 1945. Dennis H. Kelly, Sr., served as an associate editor from 1939 to 1945, and later from 1961 to 1971 held the position of Scientific Editor. These two oustanding pediatricians continue to demonstrate a keen interest in the JOURNAL and often have given me inspiration as I now serve as Scientific Editor.

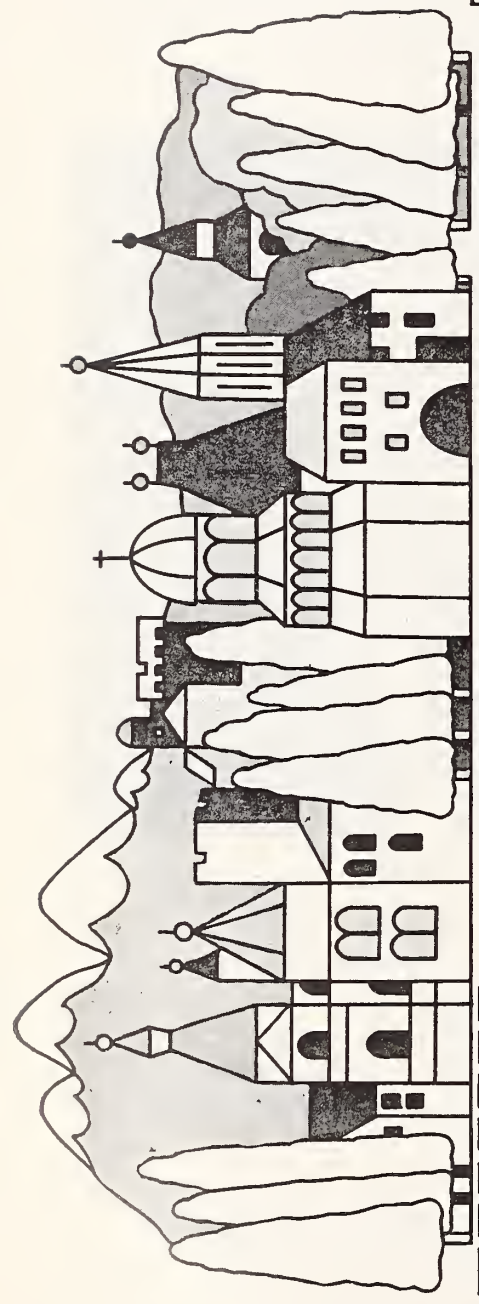
In the years after his editorship of the JOURNAL, Dr. Hill became an editor of the JOURNAL OF PEDIATRICS. He was president of the American Academy of Pediatrics and the American Board of Pediatrics. During those years, he gave freely of his time and knowledge in training his interns and residents, as well as tending a very busy private practice. His interest in pediatrics is best exemplified by a statement made by a pediatrics resident who welcomed me to the Raymond Blank Hospital for Children. His appraisal of Dr. Hill was, "If you have no interest in pediatrics now, Dr. Hill will engender some of his for you." That he did, and he continues to do so. No one could ask more of his "Chief." His life fulfills a statement made by Dr. Charles H. Mayo in the April 1928 issue of the UNIVERSITY OF TORONTO MEDICAL JOURNAL, "Once you start studying medicine you never get through with it." Dr. Hill continues to be a student, a teacher, an inspiration to all who gather around him.

Dennis H. Kelly, Sr., likewise was able to develop an intense interest in pediatrics among those with whom he associated. His interest in all aspects of medicine was always evident when he was in active practice, and later through his writings in the JOURNAL. Even during the adversity of ill health Dr. Kelly has continued to write and inspire others.

Dennis H. Kelly, Sr., M.D.

I am deeply indebted to both of these men. This issue of the JOURNAL is comprised of subjects of pediatric interest and is dedicated to Drs. Hill and Kelly. These two fine gentlemen stand as living examples of what he meant when Sir William Osler said:

*"In the records of no other profession is there to be found so large a number of men who have combined intellectual preeminence with nobility of character."*



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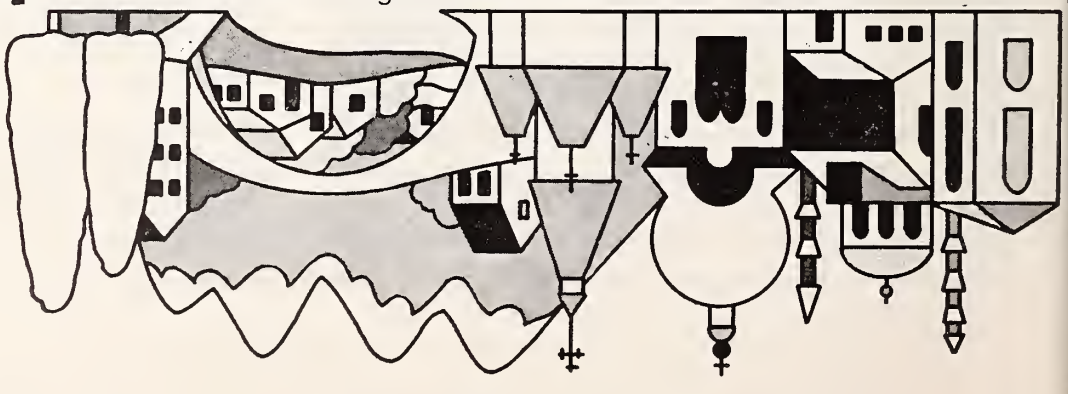


# WE'VE COME A LONG WAY BABY!

It is difficult to imagine not so long ago a baby's first months were neither soft nor safe. The infant who could not be breast fed was exposed to bacterial contamination through various substitutes for breast milk as well as an array of curious feeding devices.

Clay pots, tin vessels, flasks of pewter, silver, glazed pottery, blown glass and finally plastic have been used to give subsistence to the infant. Today's scientifically prepared formulas were preceded by the provision of milk from goats, asses and cows in various modified forms. Infant feeding devices have appeared in unusual shapes and sizes to represent an interesting chapter in the evolution of child care.

Pictured here are several of the infant feeders from the collection of Marion E. Alberts, M.D., Scientific Editor, JOURNAL OF THE IOWA MEDICAL SOCIETY.

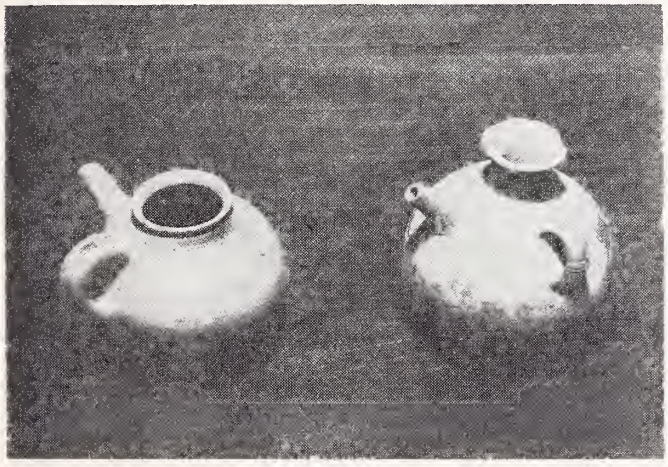
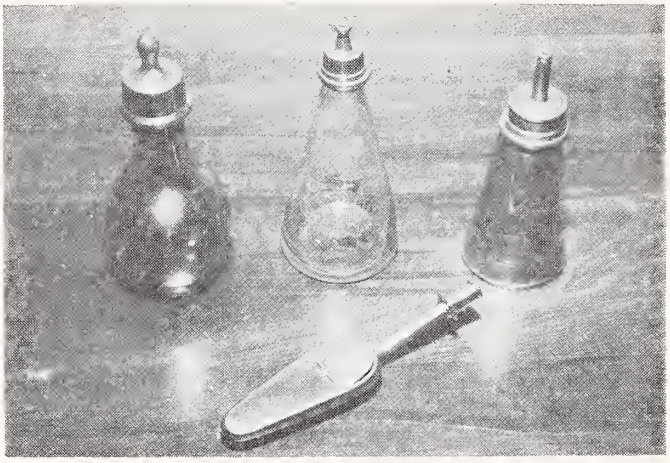


FIGURE 1



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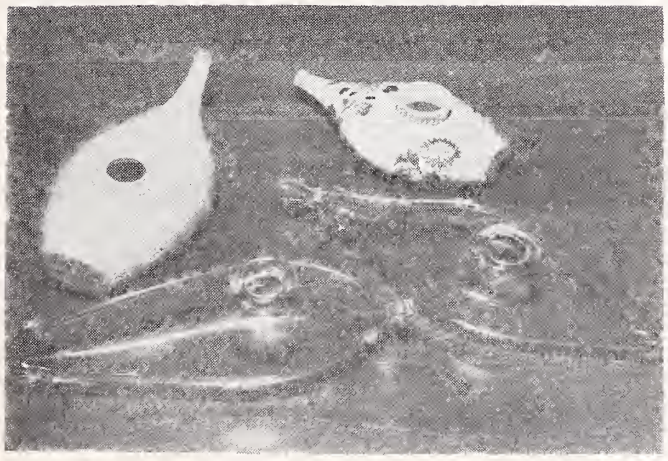

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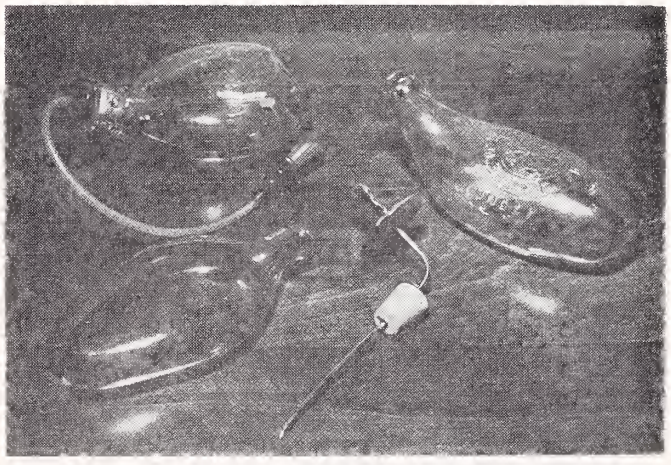

FIGURE 4

Figure 1. Ancient Persian Feeding Pots. These clay pots were found in excavations near the Caspian Sea. The one on the left (c. 200 A.D.) is unique because there is an extension of the spout on the inside so that the vessel need not be tipped very far to have a continuous flow of milk. The older vessel on the right is estimated to have been used about 250 B.C.

Figure 2. Pewter, silver, tin, and rarely, gold were used to make infant nursers. The center flask is of blown glass with a pewter nipple. The other two are pewter. A cloth or fine leather sleeve similar to the finger of a glove was tied around the open end to provide a comfortable nipple for sucking. The pewter spoon was used for medicine or food. The handle is hollow so mothers could blow through it to hasten the egress of contents. These are late 18th and early 19th century items.

Figure 3. Glass and glazed pottery nursing flasks (c. mid 19th century). The glazed pottery flasks were of graceful form and beautiful design. A cloth or fine leather teat-like nipple would be tied over the spout. The top right flask is impressed "Wedgwood." The glass flasks are hand blown and appear in various sizes and shapes.

Figure 4. Top left: Late 19th and early 20th century feeding bottle with "death-dealing" feeding tube and nipple. Top right: Up-to-date feeders (c. 1920). Lower left: Hand blown glass flask and silver nursing tube (c. 1850).

# IOWA MEDICAL LIABILITY DATA

The Iowa Medical Society is working with Rollins Burdick Hunter Company, Inc., insurance brokers of St. Louis, in the consideration of an IMS group medical liability insurance coverage for member physicians. A status report on this project was presented to the 1975 House of Delegates and the following resolution was approved by the House:

*Resolved, That the proposal for an Iowa Medical Society group professional liability insurance program for Iowa physicians, as authorized by the Executive Council and now in process of study in cooperation with Rollins Burdick Hunter Company, Inc., of St. Louis, be pursued and that a further report be made as promptly as possible to the Executive Council and the House of Delegates.*

Following are some preliminary findings from the professional liability survey distributed April 8 to members of the Iowa Medical Society:

NAME OF INSURANCE CARRIER

| PRIMARY | PERCENTAGE |
|---|---|
| Medical Protective | 50.50 |
| St. Paul | 31.70 |
| Aetna Casualty & Surety | 6.40 |
| U.S.F. & G. | 1.00 |
| Hartford | 1.00 |
| Lloyds | 1.00 |
| Travelers | 1.00 |
| Other | 7.40 |

| EXCESS | PERCENTAGE |
|---|---|
| St. Paul | 32.61 |
| Aetna Casualty & Surety | 17.69 |
| U.S.F. & G. | 8.42 |
| Chicago Insurance Company | 5.89 |
| Iowa National Mutual | 5.62 |
| Medical Protective | 3.93 |
| Employers Mutual | 2.81 |
| Other | 23.03 |

MEDICAL LIABILITY CLASSIFICATIONS OF IOWA PHYSICIANS

| | PERCENTAGE |
|---|---|
| Class 1 | 31.40 |
| Class 2 | 17.96 |
| Class 3 | 9.50 |
| Class 4 | 16.22 |
| Class 5 | 24.92 |

HAVE YOU CHANGED INSURANCE COMPANIES IN PAST YEAR?

| | | | |
|---|---|---|---|
| Yes | 3% | No | 97% |

HAVE YOU CHANGED INSURANCE COMPANIES IN PAST FIVE YEARS?

| | | | |
|---|---|---|---|
| Yes | 8.6% | No | 91.4% |

HAVE YOU HAD A MALPRACTICE SUIT OR CLAIM FILED AGAINST YOU?

| | |
|---|---|
| None | 86% |
| One | 10.3% |
| Two to Four | 3.3% |
| Five or More | .4% |

WHEN WAS MALPRACTICE CLAIM FILED?

| | |
|---|---|
| 1973-1974 | 34.39% |
| 1968-1972 | 42.08% |
| 1963-1967 | 22.17% |

ARE CLAIMS CLOSED OR PENDING?

| | |
|---|---|
| Closed | 80% |
| Pending | 20% |

HAS YOUR LIABILITY COVERAGE EVER BEEN CANCELLED OR NOT RENEWED?

| | |
|---|---|
| Yes | 7.35% |
| No | 92.65 |

HAVE YOU INCREASED YOUR LIMITS IN THE PAST THREE YEARS?

| | |
|---|---|
| Yes | 33.54% |
| No | 66.46 |

WHAT LIMITS DO YOU CARRY?

| PRIMARY | |
|---|---|
| $100/300,000 | 63.35% |
| $200/600,000 | 20.00 |
| $250/500,000 | 1.63 |
| $300/600,000 | 2.85 |
| $500/1 Million | 1.49 |
| $1 Million | 10.68 |

| EXCESS | |
|---|---|
| $1 Million | 47.78% |
| $2 Million | 20.70 |
| $5 Million | 27.38 |
| $10 Million | 4.14 |

# The Question Box

by CHARLOTTE FISK, M.D.

*Dr. Fisk has seen much progress in child care as a Des Moines physician. In keeping with the thrust of this issue, she responds to several questions pertaining to pediatrics. Dr. Fisk has served as a member of IMS Committee on Maternal and Child Health for a number of years.*

**How has pediatric care changed since you began practicing your specialty?**

Many changes have occurred in a span of approximately 30 years. Penicillin, antibiotics and steroids have changed the treatment and prognosis of several diseases. Morbidity and mortality figures have been lowered for all types of meningitis. Nephrosis no longer has a 50% mortality rate which formerly existed from associated complications. The remission cycle has been lengthened dramatically for the leukemia patient with the combination of steroids, antibiotics and antimetabolic therapy. A few patients have had long remission periods following the withdrawal of medications to the point of being classified as "cured." Early diagnosis and treatment of children with birth defects has resulted in fewer handicapped children.

**What new approaches have been introduced in infant care?**

Changes when they occur are the result of countless research programs and the implementation of that research by many practitioners. I was privileged to be part of the "team" that developed the Neonatal Intensive Care Unit at the Raymond Blank Memorial Hospital for Children in 1970. This unit offers optimal medical and nursing care for the "high risk infant." Long established neonatal centers have improved mortality and decreased the incidence of severe mental and physical handicaps in children who have received this type of care. Des Moines is expected to reflect the same improvement.

**What is your assessment of current immunization programs?**

Protection is available against whooping cough, diphtheria, tetanus, polio, rubella, rubeola and mumps. Small pox vaccination is no longer a routine procedure but is indicated for the person traveling to a country where small pox is endemic. Immunizations are available to children regardless of their socio-economic status. Parents are informed in many ways about the importance of protection for their children. The Iowa Medical Society and the county medical societies are urged to continue the efforts which have been made and are being made to assure that children are immunized against the communicable diseases.

**What's ahead for the pediatrician?**

New concepts in diagnosis and treatment will determine this. The further development of expertise in allergy, cardiology, child development, neonatology, neurology, hematology, psychiatry and surgery will lead to development of subspecialities in pediatrics. However, the role of primary care and education will continue to be paramount. This activity is exemplified by the inspirational and dedicated careers of Drs. Lee Forrest Hill and Dennis H. Kelly, Sr., both former editors of the JOURNAL OF THE IOWA MEDICAL SOCIETY. These physicians stimulated many colleagues to enter and continue in the field of pediatrics.

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SCIENTIFIC ARTICLES

# Vaginal Voiding: An Introduction

RICHARD L. VAUGHT, M.D.
Sioux City

*An infrequently recognized condition of genito-urinary problems in young females. Clinical findings and implications are presented to aid in handling "uncommon" bladder problems.*

THOSE OF US WHO TREAT URINARY INFECTIONS have no particular problem in caring for the patient with the usual cystitis or pyelonephritis by following the accepted procedures of medication, follow-up, and ruling out stone or obstruction as complicating factors. However, there are always a few patients whose problems do not fit the more common patterns of disease and who continue to have troubles despite all our efforts.

The purpose of this article is to present an infrequently recognized condition called vaginal voiding, with the hope that by understanding this condition and its clinical implications, you may be better able to offer relief to some of your patients with "uncommon" bladder problems.

Of some 850 children on whom I have kept records, there are approximately 20 with proven vaginal voiding and several in whom it is suspected on clinical grounds. Thus, it is obvious this is not a common problem, but those few patients can be the ones who drive you to despair.

Vaginal voiding is a diagnosis which may be easily missed by urologists and radiologists when it is clearly seen on x-rays. This is probably because most physicians are neither aware of the diagnosis nor familiar with the clinical findings and implications.

## WHAT IS IT?

Vaginal voiding refers to the passage of urine into the vagina during the act of voiding. (Figures 1, 2, and 3.) There are no abnormal communications or fistulae between the urinary tract and the vagina. Although not a common finding, it can be the cause of many genito-urinary problems in young girls. It is also found in the adult female, but much less often.

## WHAT CAUSES IT?

It is felt that the most common cause of vaginal voiding is deflection of the urine by the labia majora. The urine from the urethra enters the fossa navicularis which, in many girls, is virtually a closed space unless the labia are spread. This is particularly obvious in the overweight child with thick, heavy labia, but is not limited to overweight children. When the child sits on the commode, the labia do not spread, the urinary stream hits the labia, and part of it is deflected into the vagina.

Most girls in this age group are toilet trained and using the adult commode. Their buttocks are

Dr. Vaught is engaged in the practice of urology in Sioux City.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JUNE, 1975.

Figure 1. Typical A-P view with vagina filled and bladder almost empty. The urethral outline can be faintly seen through the contrast material in the vagina.

so small most of them are hanging *into* the commode rather than sitting *on* it. This position forces the thighs, as well as the labia, together. Also, this puts the vagina in a dependent position where it can catch even more urine. This position also applies to some smaller children with use of their potty chairs. Teaching the child to straddle the toilet seat will spread the thighs and labia and

Figure 2. Typical oblique view.

Figure 3. Typical lateral view.

therefore place the vagina in a better position to drain rather than collect urine.

Another cause is the swirling stream which allows a dribbling into the vagina during voiding. This can be likened to pouring water from a bottle wherein part of the fluid runs down the side and is constantly dribbling off the bottom of the bottle while you are pouring from the top. This is often seen with distal urethral stenosis or meatal stenosis (Figure 7) giving a "nozzle" effect to the urinary stream.

Children with partial fusion of the labia minora have an additional problem with drainage, as do those with hymenal septa, cribriform hymens, or a small central hymenal perforation.

## WHAT DOES IT DO?

The signs and symptoms of vaginal voiding are rather general and non-specific, and include the following:

Recurrent episodes of labial irritation constitute the most common complaint voiced by the mothers of little girls with this problem. It usually lasts only 24-48 hours, then fades out only to recur again in a few days, or a few weeks. This is

Figure 4. Showing beginning of vaginal filling at initiation of stream with full bladder.

Figure 5. Further filling of vagina as urination continues.

found in adult females also, but is seldom one of their presenting complaints.

Urinary urgency, frequency, and dysuria are almost universal symptoms. In adults, however, if they complain of discomfort with urination, it is very important to find out if the burning or discomfort occurs before, during, or after voiding. Many older women complain of discomfort in the suprapubic and urethral areas prior to voiding when the bladder is full. This is often related to atrophic senile vulvitis and secondary urethral stenosis due to the atrophy. Initial dysuria, occurring at the onset of urination, is usually associated with urinary infection (cystitis and urethritis) and most of the discomfort originates in the vesical neck area. One of the more common problems, however, is burning *after* urination. This is often indicative of vaginitis rather than cystitis. The normally acid urine gets on the inflamed vaginal tissues and causes a burning sensation which often lasts for two to three minutes following urination. Post-voiding "dysuria" is actually one of the most important symptoms for differentiating urinary infections from vaginal inflamation.

Vaginitis and vaginal discharge occur in children as well as adults. It is felt the urine causes a chemical irritation first by its acidity, then by the ammoniacal decomposition which later occurs in the vaginal vault. This is often the cause of the odor so many mothers complain about when describing their child's problem. They will often tell you how they wash the child quite frequently, but the odor remains. This often causes a mucoid discharge which accounts for the stains on the underclothes noted by some. Although urethral stenosis may be a primary problem, it is conceivable it could also be a secondary finding caused by the chronic inflammation of the vagina and urethra as a result of vaginal voiding.

Another problem which has puzzled many people is the child with "damp panties." The observant mother will tell you the child voids and then five minutes later has damp panties. The mother has usually diagnosed the problem as one of incomplete emptying of the bladder with later dribbling. Actually, the child has usually emptied the

Figure 6. Contrast material remaining in vagina after bladder is completely empty.

Figure 7. Note dilatation of proximal urethra and narrowing of distal urethra.

bladder in the normal manner but has stored some urine in the vagina (Figure 6) and when she begins to move around, the urine drains from the vagina and wets the child's underpants. The almost constantly wet panties cause the labial irritation which, as previously mentioned, is one of the most common presenting complaints.

## HOW DO YOU DIAGNOSE IT?

Although one may clinically suspect vaginal voiding, the only good way to confirm the diagnosis is by means of a voiding cystourethrogram with cine, video, or fluoroscopic control. (Figures 4 and 5) In addition one should attempt to rule out urinary infection, obstruction, and reflux. Actually, if you keep the diagnosis in mind, it is not often necessary to prove it radiographically (unless you plan to present a paper on vaginal voiding). One must also remember that this is a problem found in both children and adults.

## MAJOR PROBLEM

There are two major problems to be considered here, and they are more or less interdependent. The primary one is the collection of the urine specimen. When we consider the mechanisms of vaginal voiding, we find many of the accepted methods of urine collection are no longer valid. With normal voided urines, one cannot be sure whether the pus cells and bacteria are from the urinary tract or from the vagina. This applies also to clean catch and mid-stream urine specimens. Although it is not well recognized, the swirling stream with dribbling from the fossa navicularis is a fairly common finding by those who do many cystograms and cystoscopies, and who are in a position (literally) to observe the voiding stream. So even with the labia spread, and the urethral meatus cleansed, one can still get pus cells and bacteria washed from the vaginal area.

This bring us to what I call the "100,000 organisms fallacy." Actually, this is a misnomer, but it serves to draw attention to the frequent misuse of the concept that 100,000 organisms per cc is a "significant" number, and that less than this number can often be ignored as "not significant." The concept *is* a valid one when used properly

as it was designed. It is to be used in association with clean voided urines collected by a trained nurse who is experienced in urine collections. This concept takes into consideration the fact that there *is* contamination of the specimen by passing over the fossa navicularis and labia in this method of collection.

The 100,000 organisms concept is misapplied in two ways. Many people use normally voided urines with no cleansing and without spreading the labia. Consequently, we have seen ladies referred because of a "persistent infection" who have been treated with many different medications up to and including Kantrex and Chloromycetin, as indicated by the sensitivity studies obtained by culturing a voided urine specimen. Catheterized urine specimens on these patients are usually normal, and the cultures show no growth at forty-eight hours. The bacteria noted on the original cultures were from the vagina and perineum and could be cultured from these areas. Systemic therapy will not clear the bacteria from the perineum, and will frequently make things worse by allowing an overgrowth of yeast organisms.

This concept is also misused by some laboratories where 100,000 is accepted as the "magic number," and sensitivity tests on any specimen with less than this number of organisms are not done. Obviously, if one is dealing with urine obtained by catheterization or suprapubic aspiration, 20,000 or 30,000 or 50,000 organisms can be very significant and treatment should be guided by culture and sensitivity studies of patients with chronic infections.

The second major problem associated with vaginal voiding is dependent upon the subject just discussed. This is the problem of recurrent urinary infections. Many females, adults and children, have been repeatedly treated for recurrent urinary infections as diagnosed by examination of voided urines. The symptoms usually improve while the patient is on medication and return shortly after therapy is stopped. Many of these patients really do not have a major urinary problem, but probably are some of the most unfortunate patients we see. The patient who gets trapped between the urologist and the gynecologist doesn't seem to have a chance. The gynecologist will often obtain a voided urine and tell the patient she has pus in her urine, and there is no gynecologic problem. It is assumed some women "normally" have a vaginal discharge and labial irritation. The urologist will get a catheterized specimen, and find no evidence of infection and will tell her she does not have a urinary infection. He may also ask about vaginal discharge, pruritis, and dyspareunia. With any positive responses, he will suggest she has a gynecological problem, and she goes back and forth. With vaginal voiding, she may very well have problems in both fields.

As a minor sidelight to this discussion, we have found a large number of young women who present with a chief complaint of urinary infections, but who, after a careful history, are found to be there because of a primary problem of dyspareunia. As long as the only problem was a supposed bladder infection, which bothered only the wife, there was no great concern, but when the dyspareunia began to affect their sexual activity, and thereby affect the husband, the situation changed rapidly. The husband said, in effect, "That's enough of this stuff, if you have a problem with your bladder, get yourself in there and get it fixed!" Most of these patients are found to have vaginal voiding, urethral stenosis, or poor perineal hygiene, or any combination of these. (Some also had bladder infections.) But most of them also had a history of recurrent episodes of vaginitis.

As a result, these have been some articles published which described the reverse of vaginal voiding. Because one can so often culture the same organism from the vagina and from the bladder, some studies were done which demonstrated vaginourethro-vesical reflux. The vagina was filled with a radio-opaque solution. With straining or activity, the contrast material could be seen to reflux into the bladder. So one must consider both aspects of the problem.

## METHODS OF COLLECTION

I have discussed the methods of collection of urine specimens from female patients, but perhaps a further word on the subject may be of value. I have indicated that a voided specimen from a female (and particularly an adult female) is of no real value unless it is negative. The only valid methods of collection are by careful clean catheterization, or by suprapubic needle aspiration. There are many experts in internal medicine, or nephrology, or even in urology who will admonish you to use a catheter only if there is no other way. Even with catheterization, there is some possible chance of contamination, though of a low degree. Some physicians will suggest the use of suprapubic needle aspiration. Even though there is some risk of contamination, both are "close enough for all practical purposes." If you

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are running a research program or a teaching program where you are dealing with lab reports, tube dilution sensitivities, and statistics, there is no doubt suprapubic aspiration is more reliable. But if you are caring for patients as a primary physician, this is too costly, and not well accepted by the patients. Some of you may feel that getting a catheterized specimen is just as troublesome and time consuming, but if you have your nurse get the patient set up for a vaginal exam, it is no great problem for her to cleanse the area and get a catheterized urine specimen. For the patient with a history of recurrent urinary infections, it is particularly important to get a noncontaminated urine specimen, examine the labia, note the size of the urethral meatus, and calibrate the urethra.

## WHAT TO DO ABOUT IT?

The first rule is to be aware of the problem. If you realize there is such a thing as vaginal voiding, you are much more likely to follow the clues leading to the correct diagnosis and to relief for your patient. Next, you must remember that the infection or inflammation may be in the urinary tract, or in the vagina, or both, and to this end, you should obtain a urine specimen by catheterization or needle aspiration to determine the location of the patient's problem. (If a voided urine is negative, this is quite sufficient.) When dealing with a child, the catheterized urine is obtained at the time of cystoscopy as well as the urethral calibration. Vaginal cultures may also be of value, and an oriented history and physical is bound to help. Urethral stenosis must be searched for, and in most cases one should discuss perineal hygiene with the patient or her mother. This should include primary emphasis on wiping from the front to the back, and never from the back to the front. Many adults are surprised to hear this and to realize they may be bringing bacteria forward from the anal and vaginal areas which cause their problems. They should be instructed to wash the labia and fossa well, and to rinse carefully. After drying well, it may be helpful to use a powder or cream in this area if they have any particular problem. The mother or adult patient should be instructed to discontinue using all bubble bath or perfumed soaps. Actually, for most patients, it is not the soap which is irritating, but the perfumes contained therein. The patient should be instructed to use her fingers to spread the labia while voiding and the child taught to straddle the commode as previously described. If she has been on intermittent antibiotic therapy, one must keep in mind the possibility of a yeast vaginitis even in children.

If the patient is of an age to be engaged in sexual activity it is most important to remind her to empty her bladder after intercourse. This, in itself, solves many of the problems of recurrent cystitis. With the normal thrusting motions of intercourse, many bacteria can be forced up the short female urethra. If the patient waits until the next morning to empty her bladder, the bacteria are already eight hours ahead of her. The primary defense mechanism of the bladder is simply to flush out the infecting organisms. This is a very effective mechanism so long as the bladder is capable of emptying completely, but if there is a urethral stenosis, or edema of the urethral mucosa, the bladder may not be able to empty completely. This leaves the patient with a puddle of stagnant, infected urine trapped behind a partial obstruction. In approximately forty-eight hours, the patient again may experience the sudden, acute onset of her urinary irritative symptoms.

## SUMMARY

Vaginal voiding is a problem which is little recognized, of moderately frequent occurrence, and of great importance. I hope this presentation will help you to recognize it more often, and benefit your patient by a more rational approach to the problem.

# A Case of Congenital Pyloric Stenosis With Hematemesis and a Strong Family History

J. C. JUSTIN, M.D.
Mason City

*Two observations—inheritance and hematemesis—in case of infant with pyloric stenosis.*

THE CASE OF CONGENITAL PYLORIC STENOSIS reported here is interesting from two points of view unrelated to each other, (a) inheritance, and (b) hematemesis.

An eleven-week-old female infant with a history of vomiting since the age of three weeks was admitted to St. Joseph Mercy Hospital, Mason City, Iowa, on November 13, 1971. She had been fed several different formulas during the previous eight weeks with some success initially. During the week prior to admission the vomiting had become more protracted and projectile. The baby's weight was 10 lb. 2 oz. (birth weight 8 lb. 11 oz.). She was moderately to severely dehydrated and undernourished. Gastric peristaltic waves were visible, and a pyloric tumor could be felt. Serum electrolyte levels were as follows: sodium 133 mEq/L., potassium 3.7 mEq/L., chloride 81.84 mEq/L., and $CO_2$ content 40.38 mEq/L. Blood pH was 7.694.

All oral feedings were stopped, and the baby was given the appropriate intravenous fluids to correct the metabolic alkalosis, hypokalemia, and dehydration. Her clinical condition improved until the afternoon of the second day (November 14) when she vomited a small amount of blood. The amount of blood in the emesis progressively increased. At 10 p.m. on November 14 a nasogastric tube was inserted and about 60 cc. of bloody gastric content was aspirated. The nasogastric tube was left in the stomach, and bloody fluid continued to drain. On November 15, though her clinical condition was not satisfactory, the serum electrolytes had almost returned to normal with serum sodium 136 mEq/L., potassium 5.25 mEq/L., chloride 96.3 mEq/L., and $CO_2$ content 31.07 mEq/L. Blood pH was 7.469. Appropriate intravenous fluids were continued during this time. On November 16 at 10 a.m. a pyloromyotomy was done. Post-operatively the nasogastric tube was kept in. A small amount of slightly bloody fluid continued to drain from this tube. Approximately 3 hours after the surgery the nasogastric tube was removed, and oral feedings were started and gradually increased. She did not vomit, and her post-operative course was uncomplicated. An upper GI series done on November 20 showed no evidence of gastric ulceration. During the past three years she has had no gastrointestinal problems, and her development has been normal.

## INHERITANCE

Cockayne and Penrose[1] in 1943 suggested that a rare recessive gene was responsible for the inheritance of pyloric stenosis. Carter[2] pointed out in 1961 the risk to sons and daughters of affected individuals was as high or higher than the risk to the siblings, thus making the recessive inheritance unlikely. Carter and Evans[3] further pointed out in 1969, after carefully studying the family history of 1,168 male and 475 female patients, the genetic component in liability for pyloric stenosis is polygenic and modified by sex in such a way that girls require significantly stronger genetic liability before they develop the clinical condition. The relatives of female patients were found to be at greater risk than the relatives of male patients. For example, it was found that 18.9% of the sons and 7% of the daughters of female patients developed pyloric stenosis compared to 5.5% of the sons and 2.4% of the daugh-

Dr. Justin is a pediatrician at Park Clinic in Mason City.

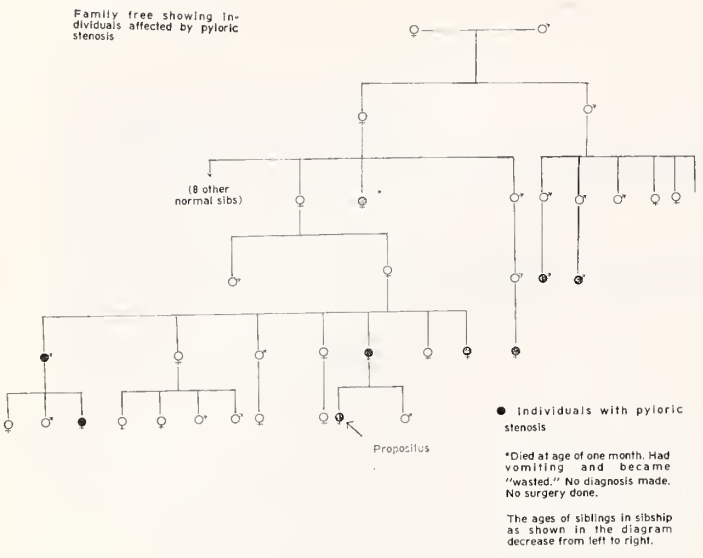


Figure 1

ters of male patients. Similarly, 9.2% of the brothers and 3.8% of the sisters of female patients were affected as compared to 3.8% of the brothers and 2.7% of the sisters of male patients. It should be noted that the overall incidence of pyloric stenosis, as determined by various studies, is about 0.5% of live-born boys and 0.1% of live-born girls.

Our patient was a female whose mother also had pyloric stenosis. As the females with pyloric stenosis carry greater genetic abnormality, there is more chance in this family of other members having the disease. One brother and one sister of the mother had pyloric stenosis. As seen in the diagram of the family tree in the sibship of the mother, two females out of five and one male out two had the disease. One daughter of our patient's uncle who himself was affected also had pyloric stenosis. Our patient's aunt who had pyloric stenosis is not married yet, but it seems that the chances of her children having pyloric stenosis are high. As shown in the diagram, three other distant relatives also had pyloric stenosis. In all the cases of pyloric stenosis shown in the diagram, surgery was done. As the genetic liability in females has to be stronger before they can get the disease, the occurrence of pyloric stenosis among different family members in this case supports the view that there is a greater chance of the relatives of the female patients having pyloric stenosis.

## HEMATEMESIS

Bleeding due to laceration of the lower end of the esophagus due to excessive vomiting like in Mallory-Weiss syndrome has not been described in infants with congenital pyloric stenosis. Moreover, this baby was vomiting for about two months; and no blood was noted in the emesis until all oral feedings were stopped. It seems likely that hematemesis was the result of gastric ulceration although no radiological evidence of it was seen four days after pyloromyotomy and cessation of hematemesis.

Hypersecretion of gastric acid in dog and man[4-6] has been shown to occur in response to partial obstruction of gastric flow. In adults, it is generally recognized that pyloric stenosis exerts an unfavorable influence on the healing of chronic peptic ulcer. Friedman and Hamburger[7] observed that an abnormally large amount of gastric secretion with more acidity was recovered from dogs with pyloric stenosis (produced by placing a heavy silk ligature around the pylorus) an hour after a test meal as compared to normal dogs. Carlos De La Rosa[8] demonstrated the formation of gastric ulcer produced by experimental pyloric stenosis in dogs. Dogs very rarely develop spontaneous gastric or duodenal ulcer. The first sign of peptic ulceration in an infant is often hemorrhage or perforation. A case of bleeding from a gastric ulcer associated with congenital pyloric stenosis was reported by David Kelsey.[9] Finney[10] in 1908 reported a case of perforated duodenal ulcer secondary to congenital pyloric stenosis.

In the case of this patient, there was no hematemesis when she was being fed milk; hence, the increased acidity in the stomach was being neutralized. Thirty-two hours after stopping the oral feedings the hematemesis started. It stopped after pyloromyotomy and resumption of milk feedings. The bleeding is felt to be the result of gastric ulceration produced by increased gastric acidity due to pyloric obstruction while the acid was not being neutralized by oral feedings.

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# Diagnosing Tuberculosis in Children

JOANNA J. SEIBERT, M.D., and
LEE FRANK, M.D.
Iowa City

*A microepidemic of tuberculosis in a rural Iowa family. Diagnostic tools helpful in diagnosis of primary tuberculosis in children.*

PHYSICIANS IN RURAL LOCATIONS may not always consider tuberculosis in their young patients with respiratory symptoms. This case report emphasizes tuberculosis still occurs and should be considered even in regions where it is uncommon such as rural Iowa.

Historical and radiographic examinations have been successful epidemiological tools in *retrospective* studies of tuberculosis. We would like to re-emphasize their *prospective* use for earlier diagnosis in children, as primary tuberculosis in the pediatric patient is usually contracted from close family members.

## CASE REPORT

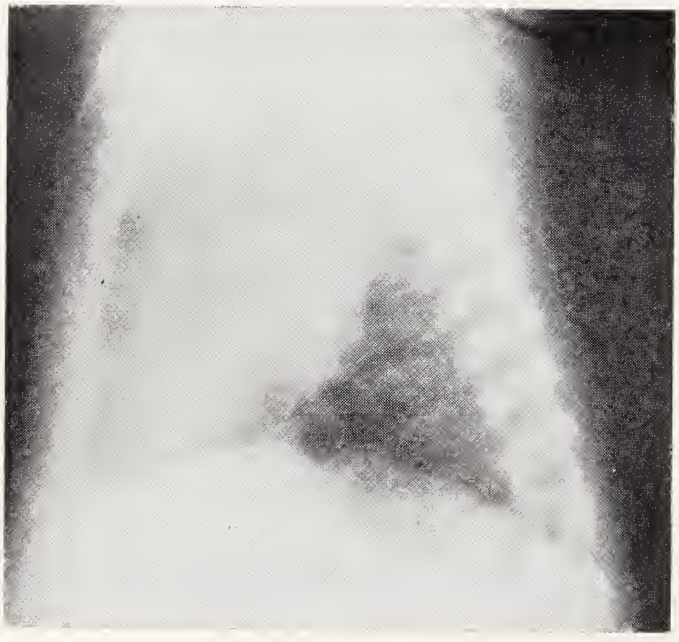
This 5½-month-old Caucasian male is one of a family of 4 small boys, whose father is a trucker and mother a housewife living in rural Iowa. He was in good health until three weeks prior to admission to University of Iowa Hospitals and Clinics when he developed signs and symptoms of rhinorrhea and a mild congested cough. His siblings had similar symptoms, but their illnesses had resolved. After 10 days, he was taken to his family physician and given a decongestant and an antipyretic for fever. The symptoms improved, but 4 days later he had increased cough and temperature of 105°. A chest radiograph revealed left upper lobe consolidation. He was admitted to his local hospital and started on oral penicillin. When he showed no improvement after several days, his medication was changed to ampicillin, and, 48 hours later, cephalexin was added.

The patient was transferred to The University of Iowa after the chest radiograph showed no improvement in two weeks. On admission, he was afebrile and in no respiratory distress, but he did have an intermittent brassy cough. Dullness and decreased breath sounds were heard over the left upper chest. There were no rales nor rhonchi. Initial laboratory data included hemoglobin of 10.7, and leukocytosis of 19,000 with a normal differential. The erythrocyte sedimentation rate was 62 mm./hr. Sputum, nasopharyngeal, blood, stool and urine cultures grew no pathogens. A Tine test applied on admission was negative at 24, 48 and 72 hours with no area of induration greater than 1 mm. Fungus titers were non-diagnostic. Chest radiograph on admission (Figure 1) and five days later showed narrowing of the left main stem bronchus and an expanding consolidation of the left upper lung with downward bulging of the major fissure. On the fifth hospital day, bronchoscopy under general anesthesia was performed. Scant, thick, whitish secretions were visualized at the entrance to the left main stem bronchus with some mucosal edema at the site; the left upper lobe orifice was not seen. Acid-fast bacilli were seen on Ziehl-Nielsen stain of the aspirated bronchial specimen. An intermediate strength P.P.D. test was then applied intradermally and revealed 15-mm. induration at 48 hours. Gastric aspirates and the bronchoscopy washings cultured *Mycobacterium tuberculosis.* Specific antituberculous chemotherapy was begun.

Upon re-questioning, the father evidenced a

Dr. Seibert is an assistant professor in Department of Radiology at U. of I. College of Medicine. Dr. Frank was a resident in Department of Pediatrics when this article was prepared and is currently engaged in a research project for Department of Pediatrics.

1a



1b

Figures 1a and 1b. AP and lateral chest of T.M., 5½-month-old Caucasian male, admitted with L.U.L. pneumonia.

Figure 2. PA chest of father showing cavitary lesion of R.U.L. and linear infiltrates in R.M.L.

history of a productive cough with hemoptysis for several months, as well as a 30 lb. weight loss. A radiograph of the father (Figure 2) revealed a large cavitary lesion in the right upper lobe with linear infiltrates in the right middle lobe. Radiograph of the asymptomatic mother (Figure 3) showed infiltration in the apical posterior segment of the left upper lung. *Mycobacterium tuberculosis* subsequently was cultured from sputum samples of both parents. All three siblings, age 2 to 4 years, had minimal upper respiratory symptoms and strongly reactive intermediate P.P.D. reactions. Two of the three had pulmonary infiltrates. However, multiple gastric washings and sputum cultures were negative for all three siblings. The eldest boy, age 4 years, had a negative chest examination but a positive intermediate P.P.D. with a 1.2-cm. reaction at 72 hours. The next oldest boy, age 3 years, had an intermediate P.P.D. positive with 2.2-cm. induration at 72 hours and an extensive infiltrate in the right upper lung (Figure 4). The 2-year-old sibling had an intermediate P.P.D. positive with 1.2-cm. induration at 72 hours and increased density in the right upper lung (Figure 5). All boys had normal lumbar punctures. None of the boys had experienced previous Tine or Mantoux testing. At last report, State Public Health officials had contacted 106 family members and close friends and found no other cases of tuberculosis.

## DISCUSSION

This case illustrates the need to consider and *reconsider* tuberculosis as a causative agent in childhood pulmonary disease. Although mortality statistics show a striking decline from the 200 deaths per 100,000 population in 1900 to the 2.7 per 100,000 population in 1970,[5] the disease is far from eradicated. Although sensitivity to tuberculin among high school and college age youth has declined from greater than 50% in the early 1940's to 4.8% in recent years, still an estimated new case load of 92,000 per year (1968) is being realized with approximately 10% of these cases in the less than 14-year-old range.[3, 8]

The recommendations for routine tuberculosis screening include Tine testing at age 9-12 months and annually thereafter. Skin testing is also recommended whenever contact with a suspected tuberculous patient is recognized.[9, 13] However, skin testing for primary tuberculosis frequently is not diagnostic. At least four to eight weeks are often necessary for a cutaneous hypersensitivity

reaction after infection. This may never occur in the setting of underlying disease with anergy as in the patient with Hodgkin's disease and other lymphoproliferative disorders.

History and physical examination in the child with tuberculosis may be negative. Presentation in this age group with productive cough, hemoptysis, fever, night sweats, severe fatigue, weight loss and chest pain is definitely the exception.[1, 4, 5, 6, 7] A brassy paroxysmal cough may be present secondary to bronchial compression by enlarged nodes.

## RADIOGRAPHIC MANIFESTATIONS

The radiographic manifestations of childhood tuberculosis also are varied.[10, 11] Often, as in this case, the radiograph shows more disease than is suspected clinically. In contrast to re-infection or secondary tuberculosis seen in adults where 90% of the disease occurs in the apices, primary childhood tuberculosis may develop in any one or several parts of either lung. All areas of the lungs are equally susceptible. The tubercle bacilli are inhaled and lodge in the pulmonary alveoli. As the disease spreads from the primary focus to the regional lymph nodes via the lymphatics, linear densities connect the primary lesion to the regional nodes. The primary focus presents on the radiograph as an area of increased density with either expansion of that segment of lung from the actual alveolar inflammatory exudate, or atelectasis or emphysema from bronchial obstruction by lymph nodes or endobronchial disease. A localized pleural effusion may be seen. Cavitation is rare. Hilar lymphadenopathy is a frequent finding in childhood tuberculosis but may be difficult to visualize when the nodes blend with the consolidated lung. Enlarged nodes should be suspected when narrowing of the trachea or a bronchus is seen on tomography or overpenetrated chest radiographs. Complete obstruction of a bronchus produces atelectasis, while partial obstruction may produce an emphysematous lobe or localized pneumatoceles. Less commonly, massive hematogenous spread of bacilli will produce miliary disease. Of 1,500 cases of tuberculosis in infancy and childhood reviewed by Gerbeaux, atelectasis or emphysema were found in 43%, mediastinal lymphadenopathy in 90% and miliary pneumonia in only 3%.[4]

Perhaps, the most useful tool in diagnosing

Figure 3. PA chest of asymptomatic mother showing infiltration of L.U.L.

Figure 4. AP chest of asymptomatic three-year-old brother with consolidation of R.U.L.

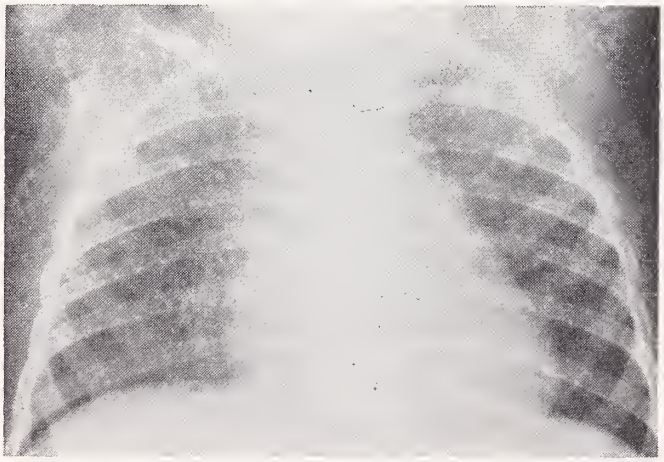


Figure 5. AP chest of asymptomatic two-year-old brother with increased density in R.U.L. with possible right hilar adenopathy.

tuberculosis in children is a thorough family history, as most tuberculosis is contracted from a member of the immediate family.[12] In one recent epidemiological study in 1971, 75% of the positive contacts for each new active case of tuberculosis were among household members.[3]

In reviewing this case, diagnosis would have been abbreviated had skin tests been performed earlier on the family members and then appropriate radiographic examinations taken. Certainly, indiscriminate radiographic examinations of entire families should be avoided. However, one has to strongly suspect tuberculosis when pneumonia in a child does not respond to the usual antibiotic course, and family members should then be re-evaluated for possible tuberculosis with the application of P.P.D. skin tests. If a history suggestive of tuberculosis or a positive skin test is obtained, chest radiographs of the family members are indicated.

## SUMMARY

A micro-epidemic of tuberculosis in a rural setting is presented. The difficulty in making an early diagnosis of tuberculosis in children is discussed as related to the reliability of the Tine test, the isolation of positive cultures and the vague symptomatology and minimal physical findings often present early in the disease. The spectrum of radiographic findings in childhood tuberculosis, as it correlates with the pathology of the disease, is described. Three simple diagnostic procedures which are usually used in the retrospective study of tuberculosis are presented as prospective aids in an earlier diagnosis of primary tuberculosis.

1. A more thorough history taking for symptoms of the disease in the immediate family.
2. Tuberculin skin testing of the immediate family.
3. Radiographic examination of the chests of family members who demonstrate a positive history or positive skin test.

We wish to thank Dr. Martin Myers, Dr. Kenneth D. Dolan and Dr. Donald Dunphy for their advice in preparing this paper.

## REFERENCES

The references noted in this article may be obtained from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

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*Indications:* Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

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*Warnings:* Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

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Overdosage should be avoided in patients severely ill with ulcerative colitis.

*Adverse Reactions:* Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

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# Segmental Infarction of the Greater Omentum

V. B. MULAY, M.D. and
H. A. GEARHART, D.O.
Dyersville
Hopkinton

*Case report and surgical treatment of segmental infarction of greater omentum in seven-year-old boy.*

THE SEGMENTAL INFARCTION OF THE OMENTUM is rare. A little over 200 cases have been reported in medical literature.

In this report, we are presenting a case and reviewing the literature.

## CASE REPORT

On Dec. 21, 1973 a seven-year-old boy was admitted to Delaware County Memorial Hospital, Manchester, Iowa. His main complaint was abdominal pain for two to three days. He had nausea but no vomiting. He was anorectic. Physical examination revealed tenderness in right lower abdomen with rebound tenderness as well. McBurney's point was very tender. The peristalsis was hypoactive.

The white blood count was 10,550, with 51% segmenters, 2% lymphocytes, and 2% eosinophils. The hemoglobin was 13.6 gm.%. The urinalysis showed no abnormalities.

Due to increasing tenderness and muscle guarding, surgery was performed. A fair amount of sero-sanguinous fluid was noted in the peritoneal cavity. The appendix was normal, but the omentum revealed a mass measuring 6 cm. x 5 cm. x 3 cm. This was dark red in color. It was resected. An incidental appendectomy was performed. The post-operative course was uneventful. The patient was discharged on the 4th post-operative day in satisfactory condition. He has remained without symptoms.

Examination of the mass from the omentum showed marked hyperemia, edema and lymphocytic infiltration and some hemorrhage into the fatty tissue. The intravascular thrombosis was noted in omental blood vessels.

## DISCUSSION

The most common symptom in patients with infarcted omentum is abdominal pain localized to the right lower abdomen. This usually leads to the preoperative diagnosis of acute appendicitis.

The first case of primary omental infarction was reported by Eitel[2] in 1899.

The infarction of the greater omentum is classified in various ways. We find the classification described by Heidayati[3] and Sconzo[3] to be the most suitable.

(A) Primary Idiopathic Segmental Infarction of the Greater Omentum

(B) Secondary Infarction of the Greater Omentum
  (1) With torsion
    (a) hernial; internal or external
    (b) nonhernial; associated with post-operative bands, adhesions, trauma and infection.

(C) Associated with vascular or cardio-vascular diseases, Buerger's disease, thrombosis of portal vein, polycythemia and cardiac disease. Most of the classifications emphasize and are based on the presence of torsion but this is superfluous and arbitrary, because symptoms, clinical findings and management are the same whether torsion is present or not.[1] In 1956, Wrzesinski[8] outlined the following four criteria for idiopathic infarction in order to differentiate from the more common secondary type of infarction.

Dr. Mulay, Dyersville, is a surgeon. Dr. Gearhart, Hopkinton, is a family practitioner. Both are on the staff of Delaware County Hospital in Manchester.

(1) The infarction must be idiopathic with no causative factor such as infection, adhesions, trauma or torsion present.
(2) The lesion must be segmental with no association of massive vascular occlusion of adjacent organs.
(3) It must be a primary process in omentum and not secondary to disease or neighboring structure.
(4) It should have the typical gross and microscopic findings especially excluding a twisted pedicle.

Freidoon Malek et al[5] emphasize that lack of history of anorexia should alert the astute surgeon about the possibility of the infarction of the omentum. However, the present writers of this article feel that it has to be an inspired guess to make such a diagnosis pre-operatively.

Schnur et al[7] describe the following mechanism for the development of the segmental infarction of the omentum.

(1) Postprandial stress on thin walled omental veins producing hemorrhage and thrombosis.
(2) Thrombosis following endothelial injury to omental veins by physical exertion or gravity or trauma.
(3) Embryologic and anatomic variation of the omentum.
(4) Gravitational stress of obesity causing rupture of omental veins.
(5) Disproportionate growth of omental fat, leading to ischemia and necrosis.

For unknown reasons, infarction occurs most commonly in the right half of the abdomen, especially the lower quadrant. All patients reported in the literature have made uneventful recovery.[4] Strangulation of the omentum in cases of diaphragmatic hernia can cause pleural effusion.[6]

As idiopathic segmental infarction of the omentum closely mimics other causes of acute abdominal disease such as acute appendicitis, acute cholecystitis or acute diverticulitis, laparotomy is mandatory and when infarcted omentum is noted, it should be excised.

## SUMMARY

A case involving the segmental infarction of the greater omentum is reported with review of some of the surgical literature.

We feel that (1) A high index of suspicion is needed to make correct preoperative diagnosis. (2) In case of "negative appendix," omentum should be inspected thoroughly and routinely. (3) Presence of sero-sanguinous fluid at the time of laparotomy should alert the surgeon to inspect the omentum. (4) Surgical treatment with excision of the involved segment is the treatment of choice since morbidity and mortality both are very low.

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# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## WHAT GOES UP MUST COME DOWN

Life has its ups and downs. We are elated with good fortune; depressed with adversity. Sometimes the heights we wish to attain, or pretend to have reached, are false or without justification. They may be insecure and unstable, and destiny has in store a sudden fall.

A recent report* in the OHIO STATE MEDICAL JOURNAL tells of severe ankle injuries as a result of wearing elevated "platform" shoes. Nieto and Nahigian report 6 severe ankle fractures and fracture-dislocations resulting from the foot being twisted on an uneven surface while the person was wearing elevated platform shoes measuring as much as 4 cm at the soles and 15 cm at the heels. For the sake of style, or because of vanity, these people suffered severe injury.

So it may be with persons who attain a false sense of importance or worth to satisfy their egos, or false valuation of their stature in the world of man. There are some of this type in our profession, as well as in all other stations of life. There is no doubt that ministering to the ills of patients can build our ego and our estimation of self-worth. Yet, are we not supposed to be humble by our training?—Yes, humble, but not weak. Our strength must be in an understanding of the people around us; we are never alone. Though we are in a profession dedicated to serving mankind, we have never reached heights of being above all others. The laborer, the handyman, the clergyman, or the top-ranking executive are all equal to us. Their position in society, like ours, is dependent upon background, education, special skills through training, experience and dedication to the purpose of their being. If we become blind to our surroundings we become oblivious of our own worth or lack of it. Though some may be very different from us, we must learn to like life for what it truly is. False attainments of self-worth will result in disaster, especially when the road becomes rough. Like the dangers of elevated shoes, we will be thrown down with pain and disability. Now is the time, when the practice of medicine looks unhappy with all the concern about liability insurance, governmental controls, high costs of living, and political unrest, that we must look at ourselves eye-to-eye. Let us not attempt to fool ourselves that we are entirely without faults.—M.E.A.

## LOUSY CITIES

Were you aware that there are a lot of lousy people in the United States? Dr. Leslie C. Norins, of American Health Consultants, Atlanta, Georgia, estimates that 3 million people had an infestation of hair or body lice during the last half of 1973 or the first half of 1974—about one million more than the previous 12-month period. These are estimates based on the sales of lice-killing chemicals.

Providence, R. I., has the dubious distinction of retaining its number one rank as the lousiest

* Nieto, E. and Nahigian, S. H.: Severe ankle injuries while wearing elevated "platform" shoes. Ohio State Med. J. **71**:137-141, 1975.

city in the United States. It held this position in 1974 and 1973. Corpus Christi, Texas, moved up from third to second, while Orlando, Florida, moved from fifteenth to fifth. Ottumwa, Iowa, ranked twenty-eighth on the 1974 rankings.

A lesson may be learned from these rankings. A high rank in a given locale should serve as a warning to nearby cities and towns. According to the report, Indianapolis was third on last year's report, and 6 months later the schools in Anderson, Indiana (40 miles away), had to be closed because of an epidemic of head lice.

During the past year I have seen 2 cases of head lice—the first I have seen in at least 12-15 years. So, beware Iowa physicians! There is a lousy city in our midst according to this report. Look closely for the little creepy crawlers. Cooties, seam-squirrels, or whatever else you wish to call them, are persistent little critters who just love people. Don't let your town or city become lousy.—M.E.A.

## IOWA MEDICAL MISCELLANY

*(Continued from page 205)*

**BLUE SHIELD DELEGATES . . .** C. W. Seibert, M.D., Waterloo, and J. D. Ver Steeg, M.D., Des Moines, were elected Blue Shield liaison delegates to the IMS.

**LIFE MEMBERS . . .** Accorded IMS Life Membership April 30 were J. B. Priestley, M.D. (posthumously), W. A. Kirch, M.D., H. A. Sohm, M.D., and J. F. Throckmorton, M.D., all of Des Moines; E. F. Kohrs, M.D., C. H. Matthey, M.D., and L. J. Miltner, M.D., all of Davenport; J. L. Kestel, M.D., Waterloo; W. A. Anneberg, M.D., Carroll; F. H. Aid, M.D., Burlington; L. A. Miller, M.D., North English; J. G. Grant, M.D., Ames, and R. T. Rohwer, M.D., Sioux City.

**PEER REVIEW ADVISOR . . .** New peer review program being implemented by the Health Facilities Association of Iowa for its nursing home members will have J. F. Veverka, M.D., Prairie City, as its medical advisor. Dr. Veverka is chairman of the IMS Committee on Medical Care in Health Facilities and Homes.

**HEALTH PLANNING . . .** Designation of Iowa as a single health service area under Public Law 93-641 has been made by Governor Ray. In so doing, provision has been made for seven southwest Iowa counties to share with an Omaha-based health system agency, and for Scott and Muscatine counties to have an affiliation with the Illowa (Illinois and Iowa) health planning agency. The IMS is to be represented on an interim HSA board which will consist of two representatives from each of the 13 existing areawide planning councils and 15 at-large members.

**MEDICAL EXAMINERS . . .** Majority of appointments to the newly-structured State Board of Medical Examiners have been made. Named to date are C. L. Beye, M.D., Sioux City, H. G. Ellis, M.D., Des Moines, J. M. Rhodes, M.D., Pocahontas, H. R. Hirleman, M.D., Cedar Rapids, Rosalie B. Neligh, M.D., Council Bluffs, F. V. Hetzler, D.O., Davenport, and Sheila Sidles, Centerville. An additional osteopathic physician and consumer are yet to be named.

**HAWKEYE SCIENCE FAIR . . .** A top winner of the HSF has achieved further recognition at the recent International Science and Engineering Fair in Oklahoma City. Holly Barrett of Essex will now participate in international competition next January in Japan. Her exhibit is entitled, "Possible Effects of Induced Anxiety."

**IOWA BLOOD COUNCIL . . .** IMS will be represented at the inaugural convention of the Iowa Blood Council to be held in Des Moines on June 27.

# State Department of Health

## HEALTH ASPECTS OF VIETNAMESE IMMIGRATION

The recent arrival in the United States of more than 1,000 Vietnamese orphan children, followed by a larger number of Vietnamese refugees of all ages, has raised many questions. What health problems and risks are associated with such persons arriving in communities throughout the nation? The exact number of refugees who will take up residence in the United States is still uncertain. Rasonable estimates are that approximately 120,000 will come, with about 2,000 in the orphan group. Although much drama has been connected with this migration to the United States, the size of the group is not remarkable when it is understood the United States admits more than 7 million aliens annually, of whom approximately 400,000 are in immigrant status.

As of the first week of May 1975, approximately 50 orphans were destined for Iowa homes, according to estimates of the State Department of Social Services. No information or estimates are available as to the number of adult refugees who may settle in Iowa. The orphan children are being processed relatively rapidly through various agencies. They are placed with pre-selected and interested families after receiving a medical evaluation and necessary treatment at various staging areas, primarily on the west coast. Other refugees are scheduled to be held for approximately 15 days in three "de-mothballed" military bases, located in California, Arkansas and Florida, respectively. Medical screening prior to clearance for immigration from these staging areas is expected to center around the detection and treatment of tuberculosis, typhoid and malaria infection and/or carriage. Persons found to be infected with tuberculosis and/or typhoid will be referred to the standard state and local public health follow-up procedures at their final destination. Children will be started on standard routine immunization regimens.

The Director of the U. S. Public Health Service Center for Disease Control has advised that for the orphan children, "major emphasis should be on getting the children into routine pediatric medical programs rather than categorizing them as threats to the public's health." Vietnam has not been infected with smallpox, and there has been no evidence of any other quarantinable diseases being found in the arriving Vietnamese orphan children. Other more common infectious diseases have been reported, however, such as chickenpox, diarrhea, pneumonia, measles, pertussis and scabies.

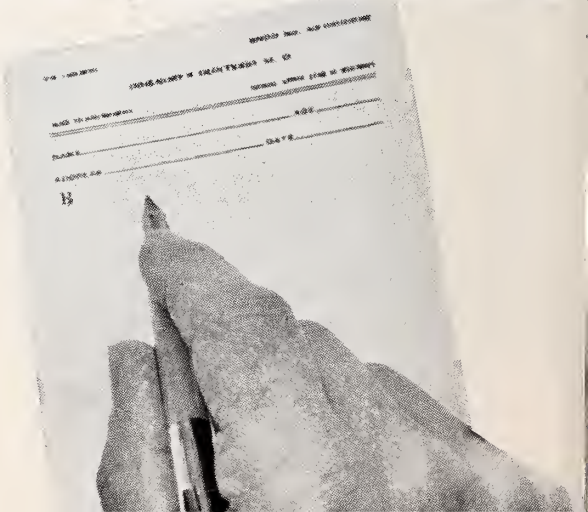
As recommendations or guidelines pertaining to adult Vietnamese immigrants become available, the State Department of Health will pass them on to Iowa physicians in a similar manner. In the meantime, physicians having questions on the subject may phone the Infectious Disease Control Section of the Iowa State Department of Health at 515/281-5424. Other pertinent excerpts from the CDC Director's memorandum concerning guidelines for handling questions regarding health risks of Vietnamese orphans are reprinted below:

### BACTERIAL DISEASES

*Enteric Diseases*—The most serious bacterial diseases that have been encountered among orphans and their contacts are the acute intestinal infections including shigellosis, enteropathogenic *Escherichia coli,* and salmonellosis in that order.

*(Please turn to page 233)*

# Bioequivalence



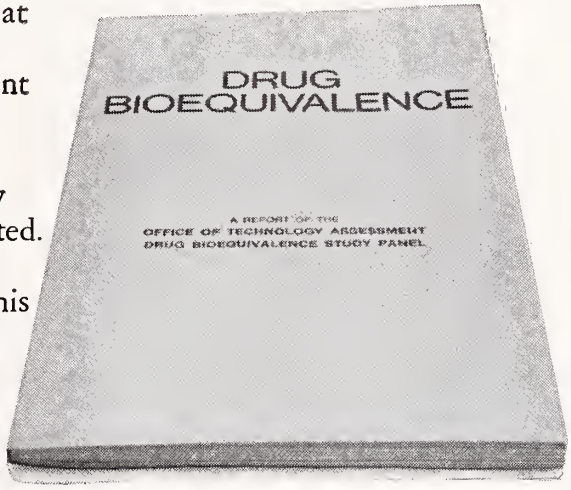
# the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.




"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

# protecting the integrity of your prescription

# Morbidity Report for April, 1975

| Disease | April 1975 | 1975 to Date | 1974 to Date | Most Cases Reported From These Counties |
|---|---|---|---|---|
| Adenovirus | 1 | 3 | 10 | Winneshiek |
| Ascariasis | 2 | 6 | 4 | Johnson |
| Brucellosis | 1 | 9 | 5 | Dubuque |
| Chickenpox | 1060 | 1538 | 4382 | Black Hawk, Dubuque, Polk, Warren |
| Combined infestations | 2 | 9 | | Iowa, Johnson |
| Conjunctivitis | 194 | 591 | 321 | Benton, Johnson, Linn, Marshall, Monroe |
| Encephalitis, type unspec. | 1 | 1 | 11 | Black Hawk |
| Erythema infectiosum | 34 | 97 | 216 | Clayton, Dubuque |
| Gastrointestinal viral inf. | 1935 | 12985 | 4669 | Bremer, Chickasaw, Dallas, Johnson |
| Giardiasis | 1 | 4 | 8 | Johnson |
| Hepatitis, A (Infectious) | 9 | 66 | 118 | Black Hawk, Fayette, Woodbury |
| Hepatitis, B (Serum) | 12 | 31 | 34 | Dubuque, Linn, Polk |
| Hepatitis, type unspecified | 4 | 11 | 14 | Black Hawk, Dubuque, Ringgold |
| Histoplasmosis | 3 | 12 | 6 | Des Moines, Johnson, Linn |
| Impetigo | 43 | 258 | 167 | Benton, Bremer, Dallas, Linn |
| Infectious mononucleosis | 127 | 597 | 414 | Black Hawk, Johnson, Linn, Polk |
| Influenza, lab confirmed | 9 | 171 | 115 | Johnson, Keokuk, Polk, Woodbury |
| Influenza-like illness | 2557 | 34446 | 88828 | Bremer (236), Dallas, Madison, Polk |
| Meningitis Aseptic | 1 | 3 | 3 | Polk |
| *Streptococcus agalactiae* | 1 | 1 | | Woodbury |
| Type unspecified | 3 | 18 | 13 | Clinton, Des Moines, Woodbury |
| Meningococcal meningitis | 1 | 6 | 4 | Dubuque |
| Mumps | 173 | 592 | 1338 | Black Hawk, Monroe, Muscatine, Polk |
| Pediculosis | 28 | 149 | 183 | Muscatine |
| Pertussis | 1 | 2 | | Woodbury |
| Pinworms | 4 | 15 | 29 | Polk, Wapello |
| Pneumonia | 69 | 513 | 424 | Scattered |
| Rabies in animals | 8 | 29 | 43 | Scattered |
| Rheumatic fever | 2 | 7 | 39 | Appanoose, Howard |
| Ringworm, body | 30 | 126 | 86 | Scattered |
| Ringworm, scalp | 2 | 6 | 5 | Madison, Winneshiek |
| Rubella | 1 | 8 | 12 | Bremer |
| Rubeola | 76 | 288 | 8 | Polk, Pottawattamie |
| Roseola | 4 | 7 | 7 | Des Moines, Dubuque, Howard |
| Salmonellosis | 9 | 54 | 53 | Carroll, Dubuque, Linn, Woodbury |
| Scabies | 52 | 188 | 38 | Black Hawk, Dubuque, Johnson |
| Shigellosis | 2 | 26 | 41 | Johnson, Scott |
| Streptococcal infections | 1094 | 4912 | 5063 | Dubuque, Jackson, Johnson, Polk |
| Tuberculosis, total ill | 23 | 39 | | Boone, Polk, Scott |
| Tuberculosis, bact. pos. | 10 | 18 | | Polk, Scott |
| Tularemia | 1 | 1 | | Warren |
| Venereal diseases: Gonorrhea | 560 | 2017 | 2023 | Black Hawk, Cerro Gordo, Johnson, Polk |
| Syphilis | 27 | 101 | 143 | Black Hawk, Polk, Pottawattamie |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | | | |
|---|---|---|---|---|---|
| Cytomegalovirus | 5 | Herpes simplex | 12 | Parainfluenza type 3 | 3 |
| Eaton's agent | 1 | Herpes zoster | 5 | | |

## STATE DEPT. OF HEALTH

*(Continued from page 229)*

No cases of cholera or typhoid have been recognized to date although both diseases are endemic in Vietnam and outbreaks of typhoid are alleged to have occurred recently in orphanages in Saigon. These enteric diseases are readily controlled by maintenance of simple sanitation, especially thorough hand-washing after nursing care of each orphan, and provision of sanitary disposal of feces.

*Tuberculosis*—Tuberculin tests should be given to all children, preferably by the intracutaneous (Mantoux) technique with the standard 5 TU dose of PPD tuberculin. A positive reaction denotes tuberculous infection, and should be followed promptly by roentgenographic examination of the chest for evidence of disease. This applies despite previous therapy or followup, or a history of BCG vaccination or presence of scar attributed to BCG vaccination. A positive tuberculin reaction in a BCG vaccinated individual may signify . . . virulent tuberculous infection . . . *(as well as)* the effect of vaccination.

If there is no evidence of disease in the positive tuberculin reactor, preventive therapy is recommended with isoniazid administered orally, over a period of one year, in a daily single dose of 10 mg. per kg. body weight for children, not to exceed 300 mg. per day. If roentgenographic findings are abnormal, further diagnostic procedures are indicated with therapy or followup *(appropriate to the degree of illness)*.

### PARASITIC DISEASES

Helminthic and protozoal infections are common among Vietnamese children. Stool exams for ova and parasites by a competent laboratory are recommended for children of all ages. Repeated stool exams may be necessary to document the presence of such parasites as *Giardia lamblia*, and *Entamoeba histolytica*. Malaria infections are more likely to occur in older children from rural areas than in infants or children from the larger cities. Any child with a febrile illness, especially if splenomegaly is evident, should have a blood examination for malaria parasites; repeated smears at 6-hour intervals should be examined if the first smear is negative. Chloroquine resistant strains of *Plasmodium falciparum* have been a significant problem. Therefore any child infected with *P. falciparum* should be treated with a regimen of quinine, pyrimethamine and sulfadiazine or dapsone. . . .

### VIRAL HEPATITIS

*Hepatitis* A—Although persons arriving in the United States from areas of the world where hepatitis A is endemic may be temporarily infected and have hepatitis A virus in their stools, the United States Public Health Service has never recommended that close personal (household) contacts of these individuals be routinely given immune serum globulin for prophylaxis. . . . *(Therefore)* CDC does not recommend the routine administration of ISG to members of a family which adopts a Vietnamese orphan.

*Hepatitis B*—Data . . . attest to a relatively high prevalence of hepatitis B surface antigen ($HB_sAg$) among people in Southeast Asia as compared with the U. S. population. However, relatively few studies of secondary transmission of hepatitis B infection to household contacts from $HB_sAg$ positive carriers have been performed. The studies which have been done, . . . indicate that the primary impact seems to be gradual acquisition of active immunity among susceptible household contacts without apparent sequelae rather than development of actual clinical viral hepatitis. CDC, in considering the management of $HB_sAg$ carriers, has been guided by the statement of the Committee on Viral Hepatitis of the National Academy of Sciences, National Research Council, "The Impact of Hepatitis B Surface Antigen in Human Blood" (MMWR 23 (14):125-126, 1974). Furthermore, as stated in the Public Health Service Advisory Committee on Immunization Practices (MMWR 21 (25), 1972) CDC does not recommend the use of standard immune serum globulin for prevention of hepatitis B.

### IMMUNIZATION

Since in most instances vaccination status will not be known nor will histories of communicable diseases be available, immunizations should be performed on all children consistent with Public Health Service recommendations.

# HEW GIVES IFMC PRELIMINARY PSRO NOD

NOTIFICATION WAS GIVEN last month (May 12) of the intention of the Secretary of Health, Education and Welfare to designate the Iowa Foundation for Medical Care as a conditional Professional Standards Review Organization.

*What does this mean?*

It means the Secretary has determined the Iowa Foundation for Medical Care is qualified to assume the duties and responsibilities of a PSRO as specified in Title XI, Part B of the Social Security Act. It means additionally that the IFMC is incorporated according to the laws of the State of Iowa as a nonprofit professional organization with a voluntary membership comprising at least 25% of the licensed doctors of medicine and osteopathy engaged in active practice.

*So what's the next step?*

For 30 days subsequent to the May 12 notification opportunity has been available for any Iowa physician to object to the designation of the IFMC as the PSRO. In the event more than 10% of these physicians advise that the IFMC does not represent them, the Secretary is required to take a formal poll to ascertain the representative nature of the IFMC. Should this polling occur designation of the IFMC would be sustained if 51% of the respondents indicate the Foundation does represent them.

On this matter of being representative, it is noteworthy to recall that pursuit of PSRO status by the Foundation has been encouraged several times by the policy-making Iowa Medical Society House of Delegates. As recently as May 1, the IMS House reaffirmed the Foundation as the appropriate PSRO organization in Iowa. In related action, the House supported current efforts to amend the federal PSRO law.

The PSRO, as stipulated by law, must operate a program which evaluates the necessity and quality of medical care delivered to individuals receiving governmentally-compensated medical care. This statutory assignment dovetails substantially with the first of the Foundation's 11 stated objectives: *"To develop, promote and encourage the distribution of quality medical services to those served at an equitable cost and in appropriate quantity."*

These recent PSRO developments coincide with the Foundation's fourth anniversary. In these formative years it is fair to say the public has been well served through the professional review services which the Foundation has made available to various third parties, e.g., insurance companies, government, etc. In its recent informational report to the Iowa Medical Society, the Foundation noted the receipt of 1,106 peer review cases during 1974; recommendations had been made on 1,059 cases. The Foundation continues to receive the support of most of the insurance carriers in the state and Blue Shield.

Building on this provision of responsible and professional peer review services, the Foundation has devoted much attention in 1974-75 to developing a formal PSRO plan. The Foundation's plan for PSRO administration, which was submitted in final form in late February, is considered a sound and workable approach to fulfill stipulated program requirements.

Embodied in the IFMC/PSRO plan are provisions (a) for coordination with involved state agencies, (b) for in-hospital concurrent medical review with a methodology for conducting admission and continued stay review, (c) for in-hospital medical care evaluation studies, (d) for profile analysis to measure effectiveness, (e) for delegation of review responsibility to individual hospital medical staffs, (f) for establishment and updating of criteria, standards and norms, (g) for linking review findings with continuing medical education, (h) for securing advice and counsel from other health care providers, and (i) for collection of necessary data.

It is believed, in view of all developments since P.L. 92603 was enacted two years ago, the Foundation has acted professionally and responsibly in bringing Iowa to the threshold of the PSRO era. The Foundation remains committed to serving the physicians of Iowa (and in turn to the public) with respect to (1) its ongoing peer review efforts, and (2) its anticipated involvement in PSRO.

# IN THE PUBLIC INTEREST

# gotten any "hot tips" lately?

Every experienced investor knows that following "hot tips" is just about the poorest way to invest! Yet all too often, acting on "tips" is what a professional person does . . . because he simply doesn't have time to investigate thoroughly. To do a first-rate job of investing you need full and adequate facts on an investment; and then must take time to analyze it adequately.

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Fortunately, there **is** a way for a busy professional person to get accurate data on which sound investment decisions can be based. It's by having a Living Trust or Investment Management Account with an Iowa Trust Department. Studying investments—all kinds—is our business. We have trained professional people . . . and we have a wealth of investment data continually flowing in that they're constantly studying. You'll get careful analysis of facts . . . and investments tailored to your particular requirements. Come in and see us for all the facts.

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# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## WHAT WILL YOU DO WHEN YOU GROW UP?

Those who have known me best know that I still, literally, ask myself the question above. And I ask it because I'm indeed uncertain what my answer is, or should be. Does it strike you as muddle-headed nonsense that a presumably responsible adult, a licensed and practicing physician, holding what might seem to be a comfortable and secure post, should make such an admission? Perhaps the puzzle will clear if you understand my notions about growth.

To me, learning is great fun. It gives pleasure to feel my mind and talents stretch, just as I gain a feeling of delight by stretching muscles upon awakening in the morning (c.f., Jacques Barzun: "The test and use of a man's education is that he finds pleasure in the exercise of his mind"). If I exploit my opportunities to learn, then I am growing in the only way that I can, now that my physical growth has ended—further physical change is likely to be in the direction of senescence. If my store of knowledge and skills increases, I might find myself able to do different things than formerly. If that change is great enough, it may even seem to represent (to some) an actual change of career. Such a change, I submit, would really represent a gradual process of becoming something different.

The notion of dynamic-vs.-static is at the basis of this discussion. The person who is kindly disposed to continuing learning can be that way only if he tacitly feels a willingness to be changed, modified, altered. He must also assume the prospect of changing his ways so much that the casual onlooker may think he is viewing a total change of role. But has the snake that just shed its skin become a new organism by virtue of its growth? Even the more dramatic transformation of caterpillar-into-butterfly really expresses a steady continuum—we are astounded only because we weren't watching carefully the events within the cocoon.

That caterpillar has no option about whether to permit such change. But humans have an incredible ability to foster or retard personal growth in the domain of learning. For example, I am unlikely to learn karate, not from mental or physical inability, but from lack of desire. But there can be no doubt—to learn is to risk some degree of transformation. The product of the metamorphosis may even defy quick recognition. And the result may lead to a new or greatly modified career. Thus it is that a truly open-minded receptivity to continuing education invites the uncertainty implied in my opening question. The trick is not to be fearful at the prospect of change, but to learn to mold it for personal and collective betterment.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

**AMA MEETING** . . . Entire thrust of 1975 scientific program at AMA's 124th Annual Convention will be toward accredited continuing medical education. The June 14-18 program in Atlantic City, N. J., includes postgraduate courses, general and specific symposia, exhibits and motion picture symposia. Fifty-two topics will be covered in postgraduate Category I courses.

# The post-T & A patient:

## another type for TYLENOL® acetaminophen products

When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

**References: 1.** Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

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# Medical Assistants

by TENORA MEYER, CMA

## 1975-76 STATE OFFICERS ELECTED

Jumer's Castle Lodge, Bettendorf, was the site April 11-13 of the 19th Annual Convention of the American Association of Medical Assistants, State of Iowa, Inc.

Alice Diehl, of the Davenport Chapter, was chairman of the convention, assisted by Helen Ceperly.

Kathryn Kirschbaum, Mayor of Davenport, and William Glynn, Mayor of Bettendorf, attended the Saturday morning opening session. Kenneth McKay, M.D., President, Scott County Medical Society, also welcomed the group.

One feature of the Saturday session was the Mini Test which is offered periodically to lend encouragement toward certification.

Joann James, Mason City, presided at the Saturday meeting of the House of Delegates. At this session, the following officers were elected for the coming year:

*President-Elect:* Leanna Rist, CMA-A, Des Moines Chapter, Des Moines, Iowa. She has been employed in the office of James A. Skultety, M.D. for 14 years. She is a graduate of St. Joseph's Academy in Des Moines and attended St. Mary's of Notre Dame and the University of Iowa. She has served on the education committee for several years and helped establish class guidelines. She became certified in the administrative field in 1973.

*Vice-President:* Margaret Porter, CMA-AC, Linn County Chapter, Cedar Rapids, Iowa. She has worked in the office of Donald D. Weir, M.D., at the St. Luke's Methodist Hospital Rehabilitation Center. She is a graduate of Mount St. Clare College. This is her second term as vice president.

*Secretary:* Pauline W. Tappan, Woodbury County Chapter, Sioux City, Iowa. Pauline is employed in the office of Drs. McFarland and Vaught, P.C. She has been an active member in the Sioux City Chapter and has held several offices. She is a regular participant in state conventions.

*Treasurer:* Twila Thompson, Des Moines Chapter, Des Moines, Iowa. Twila has been employed at the Family Practice Clinic of Drs. Olin A. Elliott, Robert J. Porter and Robert C. Larson for 15 years. She has held several offices in her local chapter and has been active in state conventions.

Nancy Winter of Davenport was installed as 1975-76 President at the Saturday banquet with Jeanne Green, CMA-A, as installing officer.

E. A. Motto, M.D., Davenport, presented a Saturday program on "Parkinson's Disease." He reported on a research project which analyzed the effect of treatment with L-dopa. The presentation included films of patients before and after L-dopa treatment in which improvement was noted.

June Hall, CMA-A, AAMA Speaker of the House, Vermilion, Illinois, presented a Saturday program on "Organizing Your Time, Personal and Professional." Following this, she spoke to the newly elected officers of the State organization.

A "Medico-Legal" Panel Discussion was held Sunday morning. Participants included James F. Bishop, M.D., John G. Ruhl, CPCU, and Robert V. P. Waterman, Attorney, all of Davenport. Jeanne Green, CMA-A, was moderator. John H. O'Connor, Business Management Associates, also spoke on Sunday.

This page is prepared for and by the Iowa Chapter, American Association of Medical Assistants. Material is compiled by Mrs. Tenora Meyer, CMA.

# About IOWA Physicians

**Dr. C. E. Radcliffe,** professor of dermatology at U. of I. College of Medicine, spoke on "Office Electrosurgery of the Skin" at February meeting of Wapello County Medical Society in Ottumwa. . . . **Dr. Harold Moessner,** Williamsburg, was guest speaker at January meeting of Williamsburg New Century Club. Dr. Moessner's topic "New Medical Science and Treatment." . . . **Dr. W. W. Southwick** has closed his Marshalltown office to join the outpatient department at VA Hospital in Des Moines. Dr. Southwick had been in Marshalltown since 1949. . . . **Dr. James Mahoney,** Council Bluffs, was guest speaker at Oakland meeting of high school students and church leaders. Dr. Mahoney spoke on drugs and teenage problems.

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**Dr. Asa Arent,** Humboldt physician for 34 years, has retired from active practice. Dr. Arent received the M.D. degree at U. of I. College of Medicine and interned at St. Luke's Hospital in Duluth, Minnesota. . . . **Drs. Joe F. Fellows** and **Peter D. Wirtz,** Des Moines physicians, have been named fellows of the American Academy of Orthopaedic Surgeons. . . . **Dr. Donald C. Zavala,** associate professor in Department of Internal Medicine at U. of I. College of Medicine, was guest speaker at recent meeting of Coralville Chamber of Commerce. Dr. Zavala's topic "The Evils of Smoking." . . . **Dr. Martin E. McKenney** has joined the Radiology Department at St. Anthony Regional Hospital in Carroll. Dr. McKenney received the M.D. degree at University of Oregon Medical School; interned at U. S. Naval Hospital, Camp Pendleton, and served his residency at U. S. Naval Hospital in Oakland, California. Prior to locating in Carroll, Dr. McKenney was a radiologist for Las Vegas Hospital in Las Vegas, New Mexico. . . . **Dr. Harley G. Feldick** has been appointed director of U. of I. Student Health Service. Dr. Feldick joined the U. of I. staff in 1971 in student health and intercollegiate team physician. He has been acting director of Student Health since 1973. . . . **Dr. Albert Dolan,** Waterloo, has been appointed chairman of the Gift of Life Program for Black Hawk and Buchanan counties. Dr. Dolan is president of the Black Hawk County Medical Society.

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**Dr. John Sear** has closed his medical practice in Alden. He has been located there since 1958. . . . **Dr. Ross C. King,** Clinton, is Iowa chairman of American Medical Society on Alcoholism, Inc., component of National Council on Alcoholism, Inc. . . . **Dr. Gerald C. Sunner,** formerly of Fort Dodge, has joined **Dr. Frank Edington** in Spencer. . . . **Dr. Warren DeKraay,** Ottumwa, spoke on vascular surgery at recent meeting of Ottumwa Rotary Club. . . . **Dr. Earle J. Stine,** Ida Grove, is new chairman of Ida County Board of Health. . . . **Dr. Hester Hursch** has joined the medical staff at John Deere Tractor Works in Waterloo. A medical graduate of University of Illinois, Dr. Hursch interned and completed her residency in surgery at Cook County General Hospital in Chicago, Illinois. . . . **Dr. John F. Hess,** Cedar Rapids, was elected president of Loras Club of CR, and **Dr. Thomas J. Schueller,** Cedar Rapids, board member. . . . **Dr. LeRoy J. Dierker** has joined the Davenport Clinic in family practice. Dr. Dierker is a graduate of St. Louis University College of Medicine. Prior to locating in Davenport in 1966, Dr. Dierker practiced medicine in Fort Madison for 18 years.

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At third annual Iowa Trauma Seminar in Waterloo, **Dr. D. J. Ahrenholz** and **Dr. R. B. Foster, Jr.,** Waterloo physicians, spoke on "Ins and Outs of Facial Injuries" and **Dr. William Bliss,** Ames, discussed "Trauma to the Trunk." . . . **Dr. J. D. Thoreson** has joined **Drs. L. W. Swanson, Stephen Westly** and **William Rosenfeld** to practice internal medicine in Mason City. A 1969 graduate of U. of I. College of Medicine, Dr. Thoreson completed his internship and residency at Presbyte-

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rian Medical Center, Denver, Colorado. . . . **Dr. Arnold Nelson,** Huxley, has been granted life membership to medical staff at Iowa Lutheran Hospital in Des Moines. Dr. Nelson has been a member of the hospital's medical staff since 1928. . . . **Dr. David McCoy,** Carroll, was guest speaker at meeting of B.L.B.F. Club in Carroll. His topic "Myths in Medicine." . . . **Dr. Najed Chaarani** is leaving Shenandoah to return his native Lebanon. Dr. Chaarani has practiced in the area since 1969. **Dr. J. G. Schaff** will assume Dr. Chaarani's practice. . . . **Dr. Tom Jessen,** Newton, presented a program on fetal monitoring at meeting of Skiff Memorial Hospital Auxiliary. . . . **Dr. E. A. Kjenaas** has joined the staff of Spencer Municipal Hospital. Dr. Kjenaas was formerly associated with the Cherokee State Mental Health Institute and the Northwest Iowa Mental Health Center. A medical graduate of University of Minnesota, Dr. Kjenaas has completed a residency in both psychiatry and internal medicine.

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**Dr. Ronald W. Miller,** formerly of Mt. Pleasant, has joined Family Practice Associates in Cedar Rapids. A graduate of U. of I. College of Medicine, Dr. Miller interned at Metropolitan General Hospital in Cleveland, Ohio. . . . **Dr. Alfred N. Smith,** Des Moines, has been named chief of the medical staff at Mercy Hospital in Des Moines; **Dr. M. Patricia Phelan,** Altoona, president-elect; and **Dr. Roy Overton,** West Des Moines, secretary-treasurer. . . . **Drs. Louis Banitt, Donald Powers,** and **William McCormack,** Ames, were program participants at series of specialty courses in Ames offered by McFarland Clinic for area nurses. New officers of Iowa Society of Anesthesiologists elected at the group's annual meeting in Des Moines are—**Dr. Charles Hull,** president; **Dr. Donald Sweem,** president-elect, both Des Moines physicians, and **Dr. Robert Beckman,** Iowa City, secretary-treasurer.

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**Dr. Kenneth E. Lister,** Ottumwa, was the guest speaker at recent local Rotary luncheon. Dr. Lister discussed the Iowa Foundation for Medical Care and answered questions relating to the future of medicine. . . . **Dr. J. G. Schaff,** former Sidney and Farragut physician, has relocated in Shenandoah. Dr. Schaff received the M.D. degree and completed his residency in internal medicine at University of Nebraska. . . . **Dr. Francis X. McCabe,** former Brookings, South Dakota surgeon, has joined the Family Health Clinic in Carroll. Dr. McCabe received the M.D. degree at Creighton University School of Medicine and served his residency in surgery at VA Hospitals in Lincoln, Nebraska and Sioux Falls, South Dakota. . . . **Dr. Paul A. Fee,** Sioux City, has been named a diplomate of American Board of Family Practice. . . . **Dr. J. B. Thielen** was recently recognized at an open house for his 30 years of medical practice in Fonda.

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**Dr. J. E. Whitmire,** Sumner, spent three weeks in February on a study mission to Africa. Along with several other midwest physicians, Dr. Whitmire visited a number of cities in Morocco, Algiers and Kenya. . . . **Dr. T. A. Bairnson,** Cedar Falls, has been named to head the scholarship program of Shattuck, St. Mary's College Preparatory Boarding School in Faribault, Minnesota. Dr. Bairnson is a 1946 graduate of Shattuck. . . . **Dr. Richard O. McClure,** Waterloo, was guest speaker at February meeting of Black Hawk County Chapter, American Association of Medical Assistants. Dr. McClure discussed autopsies.

A panel of four Dubuque physicians, **Drs. John Graves, Paul Laube, Robert Pfaff** and **Robert Vernon** discussed "Medicine in Dubuque—Its Strengths and Weaknesses" at a recent public forum sponsored by the Dubuque Democratic Club . . . **Dr. Walter Block,** Cedar Rapids, conducted a CR seminar on parent counseling for physicians and special education instructors. **Dr. Terrence B. McManus,** former Sioux Falls, S.D., psychiatrist, is new superintendent of Cherokee Mental Health Institute. **Dr. Alfred Bolch,** formerly of Dallas, Texas, has been appointed M.H.I. Chief of General Medical Services. Dr. McManus received the M.D. degree at University of Minnesota Medical School; interned at Ancker Hospital in St. Paul, Minnesota, and had a psychiatric residency at Cherokee M.H.I. . . . **Dr. John Addy,** Boone, discussed congenital defects of the newborn for a human growth and development class at Boone High School. . . . **Dr. Lynn W. Thompson** closed his Red Oak medical practice May 1 to become Chief of Outservice in Department of Medicine and Surgery at Veterans Administration Center in Sioux Falls, S. D. Dr. Thompson will also serve as faculty member of the new University of South Dakota School of Medicine. **Dr. Don E. Boyle,** Sioux City surgeon, is new chairman of Iowa Commitee on Trauma, American College of Surgeons. Dr. Boyle is also chairman of the Tri-Hospital Emergency Physicians of Sioux City.

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**Dr. Asa Arent,** Humboldt, recently received the Kiwanis Club Golden Rule award. The award recognizes outstanding community leadership and civic contribution. . . . **Dr. Philip McFadden,** Marshalltown, was guest speaker at the annual Iowa Area Recognition Day sponsored by TOPS (Take Off Pounds Sensibly) chapters of Central Iowa. . . . **Dr. Robert T. Melgaard,** Dubuque, attended a national conference on medical malpractice in Washington, D. C., sponsored by the American Group Practice Association and U. S. Representative James Hastings of New York. Dr. Melgaard served on committee of Dubuque County Medical Society which set up a malpractice arbitration panel with the Dubuque County Bar Association. . . . **Dr. Jerry L. Jochims,** orthopedic surgeon, opened his practice in Burlington in April. A graduate of University of South Dakota and U. of I. College of Medicine, Dr. Jochims practiced briefly in northwest Iowa before serving 2½ years as a Navy flight surgeon. He completed his


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residency in orthopedic surgery at U. of I. College of Medicine. . . . **Dr. Charles N. Hull,** Des Moines, is new president of Iowa Society of Anesthesiologists. Other officers elected are—**Dr. Donald L. Sweem,** West Des Moines, president-elect; and **Dr. Robert Beckman,** Iowa City, secretary-treasurer.

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**Dr. William Cannon,** volunteer medical director for the Hawkeye Regional Red Cross Blood Center, recently announced formation of a medical advisory committee to assess regional needs for blood center facilities. **Dr. Richard McClure** was named chairman of the committee and **Dr. Thomas McGarvey,** vice chairman. Committee members are—**Drs. James Collins, Neil Williams, Robert Miller, Thomas Karlowski, Dale Phelps** and **Bernard Sand.** All are Waterloo physicians. . . . **Dr. Steffen Helgaas** opened a family practice in Orange City in April. Dr. Helgaas received the M.D. degree at University of Minnesota. . . . **Dr. Gerald Sunner,** Milford, won angling recognition in the Metropolitan Miami, Florida, Fishing Tournament. Dr. Sunner caught a 9 lb. 4 oz. bonefish in the spin casting division. . . . **Drs. J. A. Bullard, T. F. Dynes,** and **D. W. Wright,** Decorah physicians, have been recognized by the Mayo Medical School in Rochester, Minnesota, for service in the preceptorship program of the Mayo Department of Family Practice Program. Certificates were presented to the physicians by Dr. Raymond D. Pruitt, Dean of the Mayo Medical School. . . . **Dr. Laurence W. Muench,** formerly of Colorado Springs, Colorado, has been named director of Department of Anesthesiology at St. Joseph Mercy Hospital in LeMars. Dr. Muench received the M.D. degree at Washington University in St. Louis, Missouri; interned at Cleveland Metropolitan Hospital in Ohio and served his residency in anesthesiology at Children's Hospital in Denver.

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**Dr. Douglas Boatman,** radiologist, and **Dr. Dennis J. Keithly,** family practitioner, have joined the Gilfillan Clinic in Bloomfield. A native of Bloomfield, Dr. Boatman received the M.D. degree at U. of I. College of Medicine, interned at Sacred Heart Hospital in Spokane, Washington

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and completed his residency in radiology at U. of I. Dr. Keithly received the M.D. degree at University of Missouri Medical School, interned at St. John's Mercy Medical Center in St. Louis, Missouri, and completed his residency in family practice at University of Missouri Medical Center in Columbia, Missouri.

## DEATHS

**Dr. Louis Goldberg,** 64, Des Moines physician for over 30 years, died March 14 at Doctors' Hospital in New York City. Dr. Goldberg received the M.D. degree at U. of I. College of Medicine in 1936 and completed his postgraduate work at Broadlawns and Mercy Hospitals in Des Moines. During World War II, Dr. Goldberg served as a flight surgeon and received over 30 citations for his distinguished service. He was a charter member of American Academy of Family Practice. The Dr. Louis Goldberg Medical Student Aid Fund has been established at U. of I. College of Medicine in his memory. Contributions to the Fund may be sent to U. of I. Foundation, Memorial Union in Iowa City.

**Dr. Frank L. Poepsel,** 74, West Point, died April 3 at St. Francis Continuation Care Center in Burlington. A 1926 graduate of U. of I. College of Medicine, Dr. Poepsel had practiced medicine in West Point since 1928. He was a member of Sacred Heart Hospital staff in Fort Madison and a past president of Lee County Medical Society.

**Dr. Carl L. Gillies,** 73, longtime radiologist at U. of I. College of Medicine, died April 5 at his home in Iowa City. Dr. Gillies was a faculty member of U. of I. Department of Radiology from 1934 until he retired in 1970. He received the M.D. degree and completed his residency in radiology at University of Michigan Medical School. Dr. Gillies was a member of American Roentgen Ray Society and fellow of American College of Radiology. Plans have been drafted for development of a Carl L. Gillies Education Center at U. of I. Contributions may be sent to U. of I. Foundation, Memorial Union in Iowa City.

**Dr. Henry S. Houghton,** 94, Dean of U. of I. College of Medicine from 1928 to 1932, died March 21 in Nashville, Tennessee. Following his tenure at U. of I., Dr. Houghton represented the Rockefeller Foundation on the China Medical Board in Peking, and was a political prisoner of the Japanese Army from 1941 to 1945. Dr. Houghton retired in 1946 and spent his later years in Carmel, California and Nashville, Tennessee.

**Dr. L. C. Pumphrey,** 73, Keokuk, died April 27 at his home. Dr. Pumphrey received the M.D. degree at University of Illinois Medical School, served his internship at Charity Hospital in New Orleans, Louisiana, and began his practice in Keokuk in 1928. Later he specialized in radiology and served three area hospitals. He was a member of American College of Radiology, Radiological Society of North America and Phi Rho Sigma medical fraternity.

**Dr. Joseph B. Priestley,** 74, retired Des Moines surgeon and former chief of surgical staff at Iowa Methodist Center, died April 28 at the medical center. Dr. Priestley received the M.D. degree at University of Pennsylvania Medical School and had practiced surgery in Des Moines for 35 years prior to his retirement in 1967.

**Dr. N. E. Weems,** 80, Paullina physician for 52 years, died April 24 at the Primghar hospital. Dr. Weems received the M.D. degree at U. of I. College of Medicine and interned at St. Joseph Mercy Hospital in Sioux City. He was a 50-year member of Iowa Medical Society and American Medical Association.

**Dr. Max T. Wainwright,** 64, Morningside, died April 28 at a Sioux City hospital. Dr. Wainwright received the M.D. degree at University of Nebraska College of Medicine. Prior to locating in Sioux City in 1946, Dr. Wainwright practiced medicine in Mapleton for seven years and served in Army Medical Corps during World War II. He was a fellow of American Academy of Family Practice.

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**Dr. Rubin H. Flocks,** 69, Iowa City, died May 17. Dr. Flocks was an internationally known urologist and a faculty member of The University of Iowa College of Medicine for 41 years. He was head of the Department of Urology from 1949 to 1974. Recipient of many honors and awards and president of the four top national professional organizations in the urological field, Dr. Flocks served as president of the Iowa Medical Society in 1973-74. Memorial contributions may be made to The University of Iowa Foundation.

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# LIST YOUR WANTS

No charge is made for the ads of members, wives of deceased members of the Iowa Medical Society or physicians seeking Iowa locations; for others the cost is $1.00 per line, $5.00 minimum per insertion. Copy for ad must be received by the seventh of the month for the following issue. Send to JOURNAL OF THE IOWA MEDICAL SOCIETY, 1001 Grand, West Des Moines 50265.

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**GENERAL PRACTITIONER NEEDED: Friendly rural community. Moville, Iowa, population 1,200, 14 miles east of Sioux City, Iowa. Unlimited opportunity for a family physician. Phone 712/873-3158 or 712/873-3455.**

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**WANTED—FAMILY PRACTITIONER—to join 8-man multispecialty group. Good progressive community, new hospital. Old established group. Liberal contract. Contact Ed Murphy, Clinic Manager, Carroll Medical Center, 502 North Court, Carroll, Iowa 51401.**

**FAMILY PRACTITIONER wanted to take over established practice with four Family Physicians in 16-man multispecialty group. Central Iowa community of 30,000. Competitive financial arrangements, many benefits, 250-bed regional hospital. Write No. 1504, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

**LOCUM TENENS WANTED—the month of October, 1975. Active rural practice, hospital in town. Salary negotiable. Contact K. A. Garber, M.D., 100 East South Street, Corydon, Iowa 50060. Telephone 515/872-2111.**

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**LOCUM TENENS NEEDED—July 3 to August 7, 1975 in rural family practice. Salary, $3,500. Housing and car available. Swimming pool and tennis court within one block. Golf course one mile outside of town. Contact W. H. Verduyn, M.D., 514 Main Street, Reinbeck, Iowa 50669. Phone 319/345-6461.**

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## INDEX TO ADVERTISERS


Burroughs Wellcome ..... 224D

Iowa Trust Association ..... 235

Lilly, Eli, & Company ..... 201
Loma Linda Foods ..... 212

McNeil Laboratories ..... 237
Medical Protective Company ..... 242

Milwaukee Sanitarium Foundation ..... 226

North Central Medical Conference ..... 208

Pharmaceutical Manufacturers Association ..... 230-231
Prouty Company ..... 241

Robins, A. H., & Co. ..... 238A-238B
Roche Laboratories ..... 202-203, 247-248
Roerig, J. B., & Co. ..... 224C

Searle, G. D., & Co. ..... 224, 224A
Shattuck, St. Mary's and St. James ..... 218
Smith, Kline & French ..... 224B
Stockdale, Inc. ..... 240

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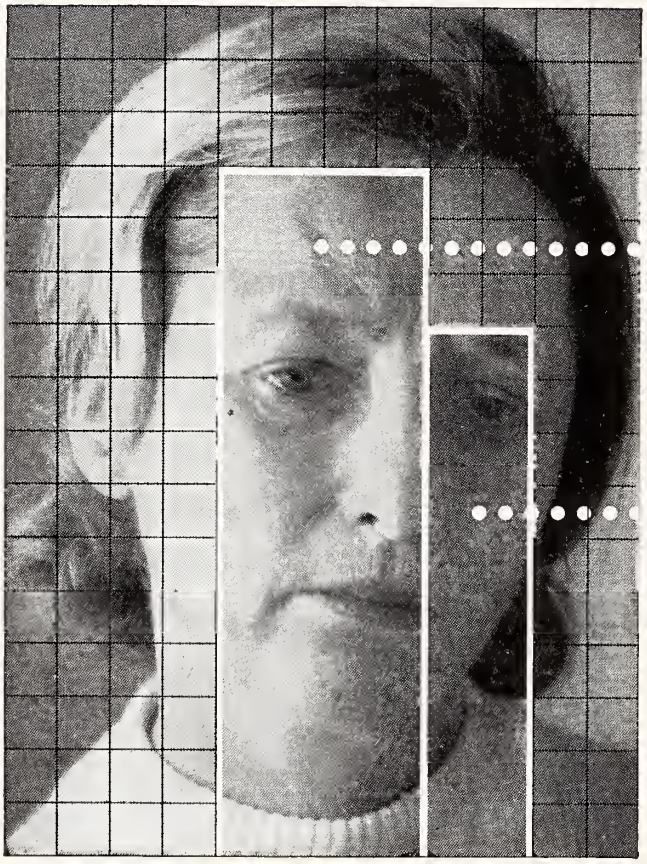
# Both often

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# respond to one

According to her major
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is is because her problem,
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nied by depressive symptom-
logy. Valium (diazepam)
provide relief for both—as
excessive anxiety is re-
ed, the depressive symp-
ns associated with it are also
n relieved.

There are other advan-
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nagement of psychoneu-
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ium is pronounced and
id. This means that im-
vement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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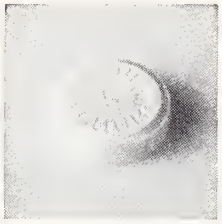

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anxiety states
with associated
depressive symptoms

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to habituation and dependence. In
gnancy, lactation or women of child-
ing age, weigh potential benefit
nst possible hazard.

**autions:** If combined with other psy-
ropics or anticonvulsants, consider
fully pharmacology of agents em-
ed; drugs such as phenothiazines,
otics, barbiturates, MAO inhibitors
other antidepressants may potentiate
ction. Usual precautions indicated in
nts severely depressed, or with latent
ession, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# President's Page

*What is the AMA doing for me? What is the IMS doing for me?*

Questions I hear frequently. And here are a few illustrations of what's being done:

The AMA filed suit February 20 charging HEW regulations violate the constitutional rights of patients and physicians. On May 27, the Court granted a preliminary injunction preventing HEW from implementing Medicare and Medicaid utilization review regulations. A permanent injunction is being sought.

The IMS House met in special session June 8 to consider the critical medical liability problem. It was a productive meeting. The detailed joint report of the Medico-Legal and Legislative Committees afforded insight to the legislative process. The session gave delegates and interested members an opportunity to be heard on this complicated subject. It underscored problems of various physicians with respect to cost and availability of coverage.

Briefly, the House (1) recognized IMS efforts to date; (2) acknowledged passage of H.F. 803; urged the finding of more long-term solutions; (3) assured that the IMS will provide expertise as possible during the interim study of the General Assembly; (4) authorized a Society fact-finding program to draw together data on which corrective action may be based; (5) endorsed an education program to increase the understanding of physicians, legislators and the public; and (6) directed that investigation be made of a statutory limit on liability, of the patient's compensation concept, of the use of binding arbitration, and of other approaches.

*Now I ask you: What are you doing for the AMA . . . for the IMS?*

Sincerely,

V. L. Schlaser, M.D.

*V. L. Schlaser, President*

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THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 7
JULY 1975

## TABLE OF CONTENTS

President's Page . . . . . 252
Fifty Year Club Members . . . . . 253
President's Address
Rapidly Changing Times
Ralph L. Wicks, M.D. . . . . 255
County Society Officers . . . . . 256
Crucial Issues Confront Medicine
Malcolm C. Todd, M.D. . . . . 257
Health Care Concerns
Mary Louise Smith . . . . . 261
Scenes from 1975 Annual Session . . 264-265
In the Public Interest . . . . . 268
Official Proceedings of the 1975 Sessions of the House of Delegates, Iowa Medical Society . . . . . 269
Reports of Officers . . . . . 271
Report of Treasurer . . . . . 273
Report of Judicial Council . . . . . 274
Reports of Standing Committees . . . . 274
Reports of Special Committees . . . . 286
Supplemental Report, Board of Trustees . 295
Iowa Foundation for Medical Care, Report to IMS House of Delegates . . . . 297
Supplemental Report, Blue Shield . . . 299
Informational Report—Scanlon Medical Foundation/Iowa Medical Society . . 301
Supplemental Reports of Standing Committees . . . . . 302
Supplemental Reports of Special Committees . . . . . 306
Resolutions . . . . . 307
Life and Associate Memberships . . . . 310
Reference Committee Reports . . . . . 312
Official Proceedings of 1975 Special Session of the House of Delegates, Iowa Medical Society . . . . . 316
Reference Committee Report on Medical Liability . . . . . 320
Officers and Committees of the Iowa Medical Society 1975-1976 . . . . . 321
Index to Minutes . . . . . 324
Morbidity Report, State Department of Health . . . . . 327

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**President's Address**

# Rapidly Changing Times

RALPH L. WICKS, M.D.
Boone

*Professional attitudes and standards must receive heavy and positive emphasis. This opinion was offered by IMS President Ralph Wicks in remarks to the Society's House of Delegates. He urged involvement by all Iowa physicians.*

During the past year since I received the honor and responsibility of serving as your President, there have been many frustrations, a few periods of satisfaction, and some sense of accomplishment. The relationship with this great group of Iowa physicians, their spouses, and their associates has been most gratifying and enjoyable.

These are troubled and rapidly changing times. There really is no end in sight to the problems. It is difficult to predict what future problems may be added to our present ones.

As an example—just one or two years ago our concern was the manpower shortage. Now we have a statewide family practice residency program responding to the manpower needs. We are beginning to see the shortage being alleviated by new graduates from the various residency programs.

## MEDICAL LIABILITY INSURANCE

Ironically, however, these new physicians are unable to care for patients in a private practice setting because many are unable to obtain liability insurance. And, if they are able to get the coverage, the cost is prohibitive for a young man who often is already saddled with debts.

The manpower problem will soon be further aggravated by the early retirement of many physicians as a result of the professional liability insurance coverage problems. While they may have a number of productive years, these physicians are frustrated by the cost of insurance and the growing belief among patients that results or treatment must either be perfect or there are grounds for filing suit.

Six legislative proposals have been submitted to our Iowa General Assembly as a beginning effort to alleviate this difficult dilemma.

The Medico-Legal Committee, of which Doctor Clarence Denser serves as chairman, has worked tirelessly on ways to solve problems in the area of professional liability coverage, as have members of the Legislative Committee, under the chairmanship of Doctor Don Young. Your officers, and staff, have likewise been deeply involved.

In further reference to legislation, it is important to note that one body of the Iowa General Assembly has already passed, as part of the criminal code revision, a section which states that it will be considered a misdemeanor (i.e., criminal act) if everything possible is not done to save the life of a fetus when it is delivered.

Who is going to determine if everything was done? Our very basic training as physicians has prepared us to preserve and save lives. Do we need legislation to empower courts to label us criminals if they decide we did not do all possible. I do not think we do.

## CONTINUING EDUCATION

As individuals, almost 100% of us have our own program of continuing education. These programs have been adequate to ensure quality medical care delivery. In the past year or so, legislators and other groups have indicated these

*(Please turn to page 260)*

These remarks were presented by Dr. Wicks on April 30 at the opening session of the 1975 Annual Meeting of the Iowa Medical Society House of Delegates.

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# Crucial Issues Confront Medicine

MALCOLM C. TODD, M.D.
Long Beach, California

*AMA President Todd highlights the pressing medical issues of the day. In remarks to the 1975 IMS House of Delegates, he called for physician involvement and unity at all levels.*

NEVER BEFORE has the medical profession faced so many issues: PSRO, government involvement in medical practice, federal regulatory mechanisms, national health insurance, and, of course, above all, professional liability. Yet medicine and doctors have never had it so good. You know that as well as I. You are held in the highest esteem of any profession or business in the United States.

I ask you to continue to serve your patients, the American people, as you have. Extend yourselves a little more, give a little bit more time to some of the things patients think about. They forget you are doing the laboratory evaluation, the x-ray review, and all of that. They think only about three or four minutes' time you give them when they come in. It is your responsibility to make them more aware.

Supporting you nationally is the American Medical Association. It is the largest medical association in the world. It is the force that should and must preserve the private practice of medicine. There should be no doubt that private medicine is the bulwark of American medicine in this country. We have no fear of diversity or pluralism. There is a place for all of these, the solo practitioner, the group practice, whether it be in a single specialty, a multi-specialty practice, the prepaid health plans, or even HMO.

Dr. Todd is the 1974-75 president of the American Medical Association. His comments here are a condensation of remarks made to the Iowa Medical Society House of Delegates April 30, 1975.

## HEALTH MAINTENANCE ORGANIZATIONS

It was partly AMA lobbying activity that kept a $5.5 billion Kennedy HMO bill from going through Congress. Working with Congressman Rogers we saw this reduced to $375 million over three years. HMO's are no fantasy, but they are in trouble, and if it were not for the federal subsidy, they would go down right now.

Then HEW Secretary Richardson made this statement in 1972, "We are going to have 400 HMO's in operation by June 30, 1973, we will have 1,400 in operation by the end of 1974, and there will be 300,000 doctors working under HMO's in the end of the 1970's." I thought that was time to challenge him, and we did challenge him, and you and I all know we are not going to work under that form of medicine in this country in 1980.

It is safe to say Americans still prefer private medicine. Private practice exists because of freedom; freedom for you to act, freedom for you to serve, and freedom for you to prescribe. We do not want to have a federal bureaucracy dictating what we are going to prescribe and how we are going to serve our people. But we must dedicate ourselves to our free enterprise system and to fiscal responsibility in government.

The strength of any organization lies in unity; unity of purpose, unity of ideals and of programming. It is difficult for an organization such as the American Medical Association to represent all political, social and economical philosophies from the ultra conservatives on the right to the extreme liberals on the left.

## UNITY AT ALL LEVELS

Medicine needs unity at the local level because of the issues at the grass roots level, and that is why your county medical society has a role to play. You need unity at the state level because state legislation is crucial right now with your Assembly in session. And certainly you need unification at the national level.

Our Washington AMA office has to dissect a myriad of medical legislation and make recommendation to the Legislative Council. The AMA

Board of Trustees and the House of Delegates help establish the policy positions. Witnesses have to be obtained to present testimony before the Congress. How could individual physicians possibly do this type of work, if it were not for a unified strong AMA voice? We would have been practicing under a totally socialized medicine scheme for the last 25 years if it had not been for the American Medical Association.

What about other AMA benefits? Do you know about the Keogh Retirement Plan. Passage of Keogh legislation is the result of AMA lobbying. There were no lawyers there. There were no architects. There were no CPA's testifying. The AMA lobbying group did this on behalf of all self-employed individuals. This is why you, and all young doctors just starting out, will be able to set aside $7,500 per year, and when you get to be 65 you will have a good fund available.

The self-employed people, the farmers in Iowa, do not know the AMA spearheaded this legislation. A group of incorporated doctors can go up to $75,000. That is still far short of what the presidents of IBM, Ford and General Motors can do in their retirement plans, but it is much better than it ever has been.

## HEALTH PLANNING

The health planning bill passed in the lame duck session of Congress was reluctantly signed by the President in January. It makes a public utility out of medicine. Ultimately, it will mean rate and fee setting for all health providers. It will tell you whether you need a hospital, whether it will be an acute facility or an extended care facility.

This is federal regulation. We no longer have just three branches of government today, the executive, the legislative, the judicial. We also have a regulatory agency.

What about the manpower bill? There is a tremendous subsidy of medical education by the government. The bureaucrats say this should allow them to say where you practice. Federal regulations should not dictate where a medical practitioner will practice. Rather, decisions about practice locations should be made voluntarily.

We must come up with viable solutions to the manpower distribution problem. How do we entice graduates of our medical schools to serve in rural Iowa, and so forth. Voluntary incentives, tax reliefs, loan forgiveness programs, and the National Health Service Corps itself are answers.

There is the subject of relicensure. Before doctors are relicensed by compulsion, we will have to insist the attorneys and the architects and the rest of the professionals are relicensed too.

## COURT ACTIONS

Last February the AMA indicated it would take the HEW Secretary to court if he insisted on implementing a free admission certification for patients under Medicare and Medicaid. And he withheld that regulation. Now he has said, "We will have 24-hour admission certification and 48-hours by a utilization and review committee." We are taking him to court on this. This action is with the United States District Court in Chicago under Judge Hoffman. Very astutely, the Secretary has said, "Well, we will move the regulations back from April 1 to July 1." Thus, we have accomplished the purpose of our preliminary injunction. Now on May 25 we will file in the same court our permanent injunction against this regulation.

The Secretary believes there has to be regulatory cost accountability in the Medicare, Medicaid, Maternal and Child Health programs. These are exactly the things we warned against when we fought the law. We said the Congress had not appropriated enough money, that it would run short.

## PROFESSIONAL LIABILITY

The professional liability problem is not going to be resolved easily. It is the most important issue that faces medicine today.

Public understanding and support is all important. This problem is going to affect the manpower pool of physicians. These new physicians who cannot purchase insurance are going to take salaried jobs in closed panel groups, or prepaid health plans, or HMO's, where the professional liability fee is paid. And what about the semi-retired doctor, 67 years of age, who is an anesthesiologist? He is willing to help his former partner who wants to take a three-week vacation or attend a continuing medical education program. But it does not make any difference whether the semi-retired doctor works a week or a month or a year. He is handed a premium of $12,500, and that's pretty nominal in our state for anesthesiologists.

I have a documented invoice of an anesthesiologist in Sacramento, California, $29,000 with a $5,000 deductible. That means the man has to

have almost $60,000 worth of business just to pay his professional liability premium. If you pay $12,000 or $15,000, that's more money than most pay annually in office rent.

My hospital in Long Beach, California, in 1965, paid a $12,000 premium, which protected interns, residents, nurses, and all orderlies and people attending patients. That went up to $47,000 in 1966. In 1974 it was $420,000; and in January of this year the hospital paid $970,000. Do you know how much that means?—$3.92 per patient per day went to pay for professional liability insurance. This is why the cost of medical care goes up. It takes $1,471 per year per bed, whether it is occupied or not, just to pay the professional liability premiums.

What is the largest suit ever filed against doctors, a million, five million, ten million? Would you believe in the Superior Court of Los Angeles County on the 29th day of November, 1974, a law firm filed for $5 billion. Do you know what the case was?

An obstetrician/gynecologist saw a menopausal woman. He did a complete physical examination and history, laboratory work, a pap smear and a pregnancy test. Everything came out negative except an abnormal pap smear. He advised the patient to return in one month for a recheck. She did not return. Later she went to see other doctors. The woman died two years later of a carcinoma of the cervix. That is what the suit is about—$5 billion.

I have high respect for, and the best of rapport with Mr. James Fellers, president of the American Bar Association. He is trying to come up with positive solutions to this problem. I think that our relationship with the American Bar Association is excellent. Needless to say, I am tremendously disturbed about the American Trial Lawyers Association. This is the only country in the world that allows a contingency fee.

## IOWA EFFORTS GOOD

I congratulate your Iowa Medical Society, your legal counsel, and your committees that are working to come up with remedial legislation. The legislative package you have introduced has come about after two months work, and I think it is really commendable.

The AMA has taken some very positive positions. We think they will be helpful. We hope our efforts have helped; we know every state operates differently. Some states need constitutional amendments. The problems are all a little different. The structure and makeup of the state legislatures vary all the way from 22% attorneys in one state legislature to 51% in another.

The AMA is recommending that where insurance is not available, that we have joint underwriting associations, these should be self-limiting associations, self-destructing in two years. You have that in your bill. This will serve a vital purpose because we need to make professional liability insurance available to every doctor.

Remedial legislation introduced at the state level needs to touch several areas: statute of limitations; a maximum allowance on awards; a measurement of damages. To simplify it, if a doctor takes off the wrong finger, why do you need to go to court about that? The patient has been injured, and that is malpractice. When the patient has been so injured, he should be awarded to the full degree. You do not have to go to court over that type of an injury. And the patient should get all of the award.

The ad damnum and the collateral source are other things involved in our professional liability situation today. The AMA sent each state society 17 pieces of model legislation. It was to be helpful in an attempt to come up with a resolution to this problem.

## LIABILITY COMMISSION

A more specific solution might be establishment in each state of a medical accident liability commission, or a screening committee of attorneys and physicians and perhaps even sophisticated consumers. We need to change the tort system. The tort system is a medieval archaic system that never can address itself to today's reality of open heart surgery, kidney transplants, aortic resections, delicate inner ear operations, craniotomies for delicate brain operations, and so forth, and every case of a bad result is not malpractice.

Medicine is not an exact science. We cannot guarantee any results. But we have a responsibility to our patients. We have to make this clear. You have to let it be understood that everything you do in their behalf cannot be guaranteed, that there is a risk in everything that is done, from an anesthesia for a normal delivery to a complicated heart procedure.

A part of our recommendation involves the development of this commission or screening committee to receive all disputed claims and re-

solve them by the process of mediation, arbitration or workmen's compensation. This is forward legislation to meet today's standards of medical practice.

We are also studying the feasibility of physician-owned mutual companies, not to be operated and run by a doctor certainly, we are not insurance people, but we would put their premiums into this company and pay a surcharge of 10% to assure proper administration.

### AMA MEMBERSHIP

I would be remiss if I did not discuss AMA membership because you are the AMA. Nobody lives up there in an AMA ivory tower and dictates this. You are the AMA. This is why it does a man no good to sit on the outside and not be part of the medical association activities. If you want to be heard, this is the place you should be heard. Let your position be clear, and you will be welcomed with opened arms into the organization.

Last year we had the largest number of membership in the history, 173,000 active dues-paying members, and with affiliates and associate memberships, it amounted to about 270,000 people. The $60 special assessment has been paid by over 117,000 doctors.

The 1975 AMA House of Delegates in Atlantic City must resolve the problem of dues. Our financial situation is the result of deficit spending five out of the past six years. If you want to have viable programs you need involvement of committees and councils and commissions. You have to have money to do this. You will instruct your delegates how to vote when they go to Atlantic City. I remind them and you that no organization can be strong and healthy unless it has the financial support. Let yourself be known as to whether the organization is doing the things you want it to.

### UNIONISM

I hear about unionism. I hear about the council of medical staffs. I am a member of AAAPS, but it is almost out of character for a doctor to belong to a union. The only way a union is effective is to act collectively and make those decisions themselves, not you as an individual, and you became a doctor because of your individuality.

The AMA has organized a new Department of Negotiations. This is a progressive step. It will be a move forward to meet today's issues and challenges.

I personally believe every active physician, every doctor in private practice and every researcher, ought to belong to AMA first. Sure he has to belong to the academic professional societies. I belong to the American College of Surgeons and all the surgical societies, and the Academy of Family Practice. By involvement you will be in a position to influence policy positions of the association.

Medicine is changing and the American Medical Association is changing. We are changing to help in the scientific field, where we have done a good job, but we are changing to meet some of the social and human needs of our society, to improve the quality of life of our Americans, and this is where the doctors of this country can plan a vital role.

## RAPIDLY CHANGING TIMES

*(Continued from page 255)*

studies should be recorded and documented as a prerequisite to continued medical licensure.

Your Iowa Medical Society and the State Board of Medical Examiners have made studies and recommendations to this House of Delegates to satisfy the "consumer." I hope the ultimate actions of both the Iowa General Assembly and our profession will permit the elements flexibility and individuality to remain.

### PATIENT NOW CONSUMER

This is a brief resume of a few of our problems. They are not insurmountable. But it is evident that we must consider the *consumer,* who was until recently our *patient.* He is now represented by many so-called experts in the delivery of health care—the legislators, the bureaucrats in Washington, the press, and other organizations—springing up with great regularity.

Unfortunately, we still have many problems confronting us. But the challenges have been met in the past, and I am confident they will be successfully resolved in the future. We must maintain our genuine regard and compassion for our patients. We must uphold our professional attitudes and standards. We must remain involved and encourage our younger colleagues to become involved.

# Health Care Concerns

MARY LOUISE SMITH
Washington, D. C.

*National Republican Party Chairman Smith presented the 1975 Iowa Medical Society House of Delegates this appraisal of government's role in health care. She urged physicians to make their voices heard in the quest for responsible government.*

I AM DELIGHTED to be among so many old friends. I once saw home defined as that special place where your faults are forgiven and your accomplishments magnified. Whether that is the reason or not—it is very good to come back after being gone for what, in many ways, seems like a very long time.

I have found that serving as Republican National Chairman is both a difficult and a challenging job. It is made somewhat easier by the fact that I am working closely with people who are committed to building a better government.

During the year I have spent in Washington, I have become more and more deeply impressed with how much America needs that kind of commitment.

I have discovered I am very much a product of America's heartland where our values are basic and deep-rooted. I must confess I thought just about everyone shared these traditional goals—things like individual initiative, individual responsibility, individual freedom. But I am no longer certain these things are as important to everyone as they are to us here.

The thing that has disturbed me most in Washington has been watching the growth of government . . . and the grip government has on the lives of Americans.

I grew up believing the purpose of government is to serve the people. I have found too often government overwhelms instead of serving . . . too often the government is setting standards for the people instead of the people setting standards for the government. It seems to be a cycle that feeds on itself.

As Congress appropriates more and more money for more new programs, the government grows. As more money is spent, there is more need to control the way it is spent—and government grows. More control requires more money for more new bureaucratic operations to provide this protection—and so government grows again.

There is a strong resistance to ending existing government programs because, whether they are working or not, someone is benefiting from them . . . even if it is only those who administer them. It is difficult to cut back. It is just one more example of that old cliché about the squeaky wheel getting the grease. About the best solution I can see is to develop a new breed of squeaky wheels.

The only way to return traditional American values to government is for those of us who believe in these values to make our voices heard.

For everyone that sits back and lets others run the government . . . someone will fill that vacuum. Their views may not represent yours, but they are there speaking for you. Over the past several decades there has been a phenomenal growth of government and bureaucracy, much of which has steadily chiseled away at our personal freedoms.

This is not to say that all government is bad. All of us can cite examples of progress and accomplishment that could not have been achieved any other way. There are needs to be met and things government should and must do. The problem is one of degree and direction.

Just as some government is good, some new government programs are necessary to serve the best interests of this nation. The problem arises when we attempt to persuade lawmakers that because some is good, it does not follow that

Mrs. Mary Louise Smith is chairman of the Republican National Committee. A native Iowan, Mrs. Smith also served as National Committeewoman for Iowa.

more is better. The health care field stands out as an example. Look at what government is doing in health care—some good and some very controversial.

The February issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY provides an impression of the magnitude of it all. As the JOURNAL pointed out, more than 26,000 bills and resolutions were introduced in the 93rd Congress. Of these, more than 2,700 were of interest to medicine.

The thing that immediately struck me when I began looking into the government role in health care was the dramatic increase in federal expenditures. Federal health outlays have more than doubled since 1969. In 1976, they will total 38 billion dollars—8% more than this year. There are 4.5 million people employed in the health care industry—twice the number of 25 years ago. Annual expenditures for health care may exceed $125 billion in 1976.

"This means," said one top HEW official, "we can't afford the luxury of unprogrammed hit-or-miss expansion of health facilities and services." As most of you are well aware, the government has shown no inclination to let that happen.

## HEALTH PLANNING

One of the newer programs is the Health Planning and Health Resources Act, which sets up a complex network of health care decision makers including health systems agencies, state health planning and development agencies and statewide health coordinating councils. This law will incorporate the private sector in its implementation. This means both individuals and associations can have a voice in how it is implemented. But only those who speak up will be heard.

Another government thrust is toward formation of Health Maintenance Organizations. In 1973, Congress voted 325 million dollars to support and develop Health Maintenance Organizations over the next five years. The rationale behind these federal dollars was an attempt to "develop prepaid health care organizations as an alternative . . . to the traditional fee-for-service method of providing the people of this country with health care."

The government also has assumed a significant role in medical education. As Secretary Weinberger told Congress, "Over the past decade, the nature and extent of federal intervention in the health care system and its associated education and training programs have grown substantially. . . . Federal funds from all sources now account for nearly 50% of the revenue to U. S. medical schools, making the federal government the largest single supporter of medical schools."

The Secretary proposed significant changes in federal policy and spending patterns which would focus more directly on better distribution of medical personnel and more efficient use of paramedical personnel. The Administration proposal also would reduce unnecessary and inequitable federal subsidies for health, professional schools and students.

HEW has given top priority to a program of screening children of families eligible for Medicaid—an attempt to catch medical problems early. The national goal this year is to bring 3 million eligible children into screening and treatment.

The government currently is putting pressure on insurance companies to continue writing malpractice insurance. As you know, the increasing difficulty physicians in some areas face in obtaining insurance has reached crisis proportions. Doctors in at least seven states face the prospect of not being able to obtain malpractice insurance when their present policies expire. The current policy of HEW is to keep federal involvement in this area temporary. Secretary Weinberger has said he is convinced the states and the private sector can resolve the present crisis and find permanent solutions to the medical malpractice problem.

Also underway in Washington is the development of a National Health Strategy. It is a complex and detailed strategy generally embodied in the Forward Plan for Health. Part of the impetus for developing such a strategy is the increasing billions of dollars Americans spend for health care. However, the primary reason is the extent to which rising health expenditures have been met by public funds—especially federal funds. Today federal dollars pay for about one-third of all the health services furnished in this country.

One of the major assumptions of the Forward Health Plan is that by 1980 there will be some form of National Health Insurance. What form such insurance will take still is unclear. The administration proposal would call for a largely voluntary national health insurance. This proposal has been put on the back burner for the moment because it would increase federal spending which

President Ford has said must be held down. But the administration is still committed to its eventual enactment. There are many other health insurance proposals before Congress. Among those favored by the Democrats, one of the best known is being promoted by Senator Kennedy. It would provide a federally-funded National Health Insurance Program at roughly 10 times the cost of the administration proposal. Any of you who have dealt to any extent with Medicare and Medicaid have some idea what this proposal would mean if it were ever enacted.

There are two other very controversial developments we should touch on briefly, because both will have a considerable impact on you as practicing physicians. One is the introduction of Professional Standards Review Organizations. The other is Utilization Review.

The purpose of these measures, in the words of Secretary Weinberger, is "to enable the medical profession to determine that the care paid for by Medicare, Medicaid, and Maternal and Child Health programs is of acceptable quality, consistent with the needs of the patient, and provided in the most appropriate setting."

Utilization Review, which will go into effect July 1, will—among other things—exercise control over whether Medicaid and Medicare patients should be hospitalized and for how long.

The Professional Standards Review Organizations will review—on the basis of pre-established norms—the services a physician provides to Medicare and Medicaid patients in an institution. Eventually there will be 203 Professional Standards Review Organizations across the country.

## GOVERNMENT INVOLVEMENT

This is but a tiny sampling of government's involvement in health care. Government's role increases almost daily. There obviously are those who believe this greater government presence is both necessary and desirable . . . because it doesn't just happen. Someone is passing the laws that make it happen. If you agree with this strategy, you are being well represented in Washington. If you don't agree, you have two primary options. You can sit back and complain about it. Or, you can get involved in electing people to office who will do something about it.

Some of you, I am sure, are thinking . . . well, I would like to, but I'm so busy. I really do not have time for politics. I urge you to reconsider. There is no one who has more reason to be involved in politics than a physician.

Organizations such as the Iowa Medical Political Action Committee deserve praise for their work and for their commitment to the position that electing good men and women to national and state offices is the best way to assure the conscientious enactment of legislation which is in the public interest.

## POLITICAL PARTICIPATION

But even if you work for IMPAC, this is not enough. I urge everyone of you to become deeply involved in the activities of one or the other of the political parties. The parties are the ongoing entities that provide continuity, stability and balance for our political system. Parties, in order to be effective, require money, they require people, and they require spirit. This group can provide all three.

Under the new Campaign Reform Law, there are some good things and some bad, some are being challenged, but if it remains as is, one thing the law does is to increase the role of parties in our elections, both on the state and national levels. Involvement means more than voting on election day, much more. It means working in voter registration drives. It means helping select party leadership. It means supporting candidates, or possibly running for office yourself. It means doing all you personally can do to make sure that 1974, when only 39% of the people went to the polls, was the low point of voter turnout. We must never allow that kind of apathy again if we are indeed going to have government by the people.

Increased involvement in our political system at every level, increased activity in our political parties will result in closer citizen control of our government. It will provide better candidates for public office, demand greater accountability on the part of our public officials and assure that those who govern are in tune with those they represent.

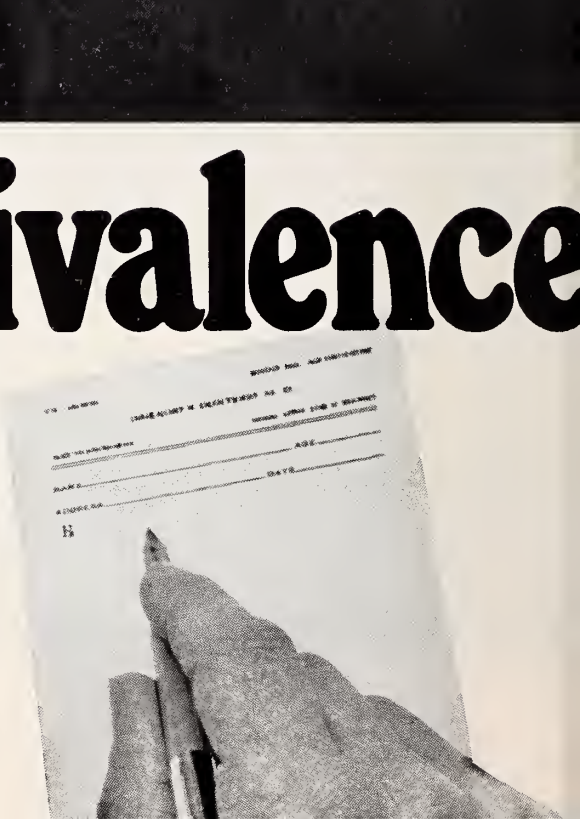
Change comes as a result of raised voices. It is a response to those who work to make the system better, not those who stand aloof and criticize. If you do not care enough about your beliefs to stand up and really fight for them in an aggressive, active kind of way, I would close with this question: *If you don't do it, how can you honestly expect that anyone else will do it for you?*

# IMS House of Delegates in Annual Session

Scenes from the 1975 Annual Session of the Iowa Medical Society House of Delegates held April 30/ May 1 at Johnny and Kay's Hyatt House in Des Moines. Important topics debated included professional liability, continuing medical education and PSRO.

LEFT PAGE—Upper: (Left) R. F. Birge receives the 1975 Merit Award from J. F. Bishop. (Center) D. L. Taylor is honored on his retirement as IMS Executive Vice-President. (Right) J. Merrill Anderson, left, receives the Washington Freeman Peck Award on behalf of the Iowa Farm Bureau from R. L. Wicks. Upper Middle: (Left) D. C. Young, IMS Legislative Chairman, addresses the House. (Right) J. P. Ver Steeg engages in House debate. Lower Middle: V. L. Schlaser is installed as IMS President by Dr. Wicks. (Center) C. E. Radcliffe, Blue Shield Board Chairman, reports to the IMS. (Right) AMA President Malcolm Todd chats with Mary Louise Smith, Republican National Committee Chairman. Lower: (Left) D. M. Youngblade, left, Judicial Council secretary, and J. E. Tyrrell, right, Council Chairman, confer with new member A. L. Sciortino. Right: IMS Board Chairman J. F. Bishop, left, presents AMA-ERF check to P. M. Seebohm, Executive Associate Dean U. of I. College of Medicine. RIGHT PAGE—Left: Paul Norris, Marshalltown, left, receives the John F. Sanford Award from Dr. Wicks. Center: A. W. Boone presents report of Reference Committee on Reports of Officers and Miscellaneous Business. Right: J. H. Lohnes gives report of Reference Committee on Legislation and Medical Service. Middle: Left: AMA Past-President D. F. Ward receives silver tray from Dr. Wicks. Center: F. M. Ashler was chairman of Reference Committee on Articles of Incorporation and By-Laws. Right: R. C. Hardin, right, receives Ben T. Whitaker Award from S. P. Leinbach. Lower: New IMS Life Members, from left, W. A. Anneberg, Carroll, J. G. Grant, Ames, and J. L. Kestel, Waterloo. Right: IMS officers, standing from left, C. D. Ellyson, Waterloo, vice president; T. A. Burcham, Des Moines, treasurer; Hormoz Rassekh, Council Bluffs, trustee, and W. R. Bliss, Ames, secretary. Seated, from left, V. L. Schlaser, Des Moines, president, and A. J. Havlik, Tama, chairman of the Board.

# Bioequivalence



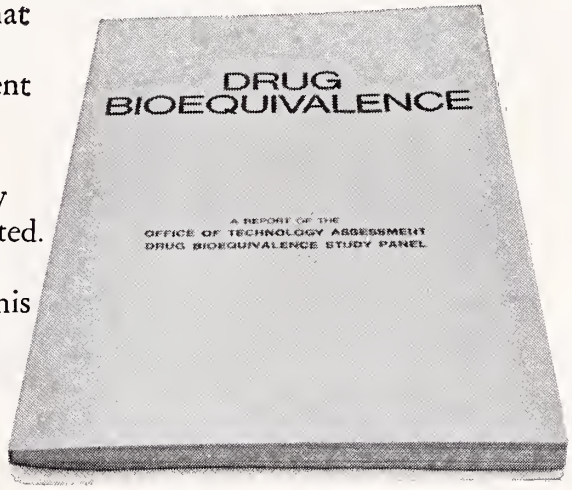
# the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.




"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

# protecting the integrity of your prescription

# A TOP PERFORMANCE

WHEN YOU HEAR the words *doctor, electrician, pilot, policeman,* etc., you rather easily visualize the respective duties which are involved. But when you hear someone described as an *association executive* some uncertainty may settle in your mind. What's an *association executive?*

This individual must be diversified in his capabilities. He needs to be an administrator, a communicator, an innovator, etc., etc. In other words, to be effective, he has to be a sort of *rare bird.*

One such *rare bird* has served the Iowa Medical Society for nearly 30 years. In this time interval, Donald L. Taylor has come to be recognized as one of the nation's most able medical association executives. In support of this declaration is his service as a president of the American Association of Medical Society Executives.

On June 1, 1975, Mr. Taylor retired as executive vice-president of the Iowa Medical Society. He has served in this capacity since 1953. While he makes this move for health reasons, he will continue his service to and employment with the Society as an executive advisor.

As chief administrative officer for the professional organization of Iowa physicians, Mr. Taylor has had the unique distinction of knowing and working for more medical doctors in the state than perhaps any other lay person. His performance has been praised by many of his physician employers and is possibly best capsulized by wording on the John F. Sanford Award which was presented to Mr. Taylor in 1964. It reads:

*". . . to Donald L. Taylor whose significant achievements on their behalf and whose dedication to their ideals and aspirations is gratefully acknowledged by his warm friends—the physicians of Iowa."*

Mr. Taylor has served with distinction in numerous capacities related to his primary assignment as IMS executive vice-president. He has been EVP of the four-year-old Iowa Foundation for Medical Care. In addition, he has been (and will continue to be) secretary-treasurer of the Scanlon Medical Foundation/Iowa Medical Society. He has served as secretary-treasurer of the Iowa Health Council. He is a past-president of

Donald L. Taylor

the Iowa Society of Association Executives and is a Chartered Association Executive (CAE) of the American Society of Association Executives.

Looking to the future, Mr. Taylor will become president of the Professional Convention Management Association in 1976. He is now first vice-president. PCMA is the national organization which represents all of the legitimate health professions in planning effective medical meetings.

Obviously, the delivery of medical care has progressed dramatically during Mr. Taylor's 30 years of service. For example, in this time frame, Blue Cross/Blue Shield has emerged in Iowa as a positive health care financing mechanism. Significant administrative leadership has been given to this process by Mr. Taylor. The growth of Iowa's medical education capability has been similarly impressive—carrying in the process the support of the Iowa Medical Society. The active pursuit of good medical legislation has also had a priority classification over the past three decades.

In these areas—and in all Medical Society endeavor—the routine has involved (1) policy-making by the IMS House of Delegates and/or Executive Council, and (2) strategy development and execution by the Board of Trustees and various Society committees—with ongoing administrative support provided under the conscientious direction of Mr. Taylor.

# IN THE PUBLIC INTEREST

# OFFICIAL PROCEEDINGS

# 1975 HOUSE OF DELEGATES
# APRIL 30-MAY 1, 1975
# DES MOINES, IOWA

(Alphabetical Index—Page 324)

## WEDNESDAY SESSION, April 30, 1975

The House of Delegates of the Iowa Medical Society was called to order by the Speaker L. D. Caraway, M.D., of Amana, at 9:10 a.m., Wednesday, April 30. The House approved the taking of attendance by signed registration cards. There were 126 delegates, 20 voting alternates and 14 ex-officio members present.

| COUNTY | DELEGATE |
|---|---|
| Appanoose | A. S. Owca |
| Audubon | R. M. Mason |
| Black Hawk | A. M. Dolan |
| | M. N. Williams |
| | R. S. Gerard |
| | W. M. Kelly |
| | R. T. Guthrie |
| | R. R. Roth* |
| | C. D. Ellyson* |
| Boone | E. E. Linder |
| Bremer | G. J. Kimball |
| Buchanan | P. J. Leehey |
| Butler | F. O. Rolfs |
| Calhoun | R. P. Ferguson |
| Cass | T. J. Payne |
| Cerro Gordo | G. H. West, Jr. |
| | R. E. McCoy |
| | D. D. Van Etten |
| | W. C. Rosenfeld |
| | W. G. Garrett* |
| | D. E. Fisher* |
| Cherokee | G. E. Michel |
| Chickasaw | P. A. Searles, D.O. |
| Clarke | J. D. Kimball |
| Clay | J. X. Tamisiea |
| Clayton | J. D. Compton |
| Clinton | G. L. York |
| | G. T. Schmunk |
| Crawford | D. J. Soll |
| Dallas-Guthrie | E. E. Lister |
| | N. L. Krueger |
| Davis | H. M. Perry |
| Decatur-Ringgold | D. E. Mitchell |
| Delaware | J. E. Tyrrell |
| Des Moines-Louisa | K. A. Hahn |
| Dickinson | D. F. Rodawig, Jr. |
| Dubuque | J. W. White |
| | R. T. Melgaard |
| | K. K. Hazlet |
| | J. S. Chapman |
| Emmet | R. J. Dawson |
| Floyd | E. E. Schmiedel |
| Fremont | F. M. Ashler |
| Greene | R. W. Burke* |
| Grundy | D. R. Kruschwitz |
| Hancock-Winnebago | L. R. Fuller |
| Hardin | T. C. Graham |
| Harrison | J. W. Barnes |
| Ida | J. B. Dressler |
| Jackson | J. A. Broman |
| Jasper | T. E. Kiernan |
| Jefferson | W. C. Baumann |
| Johnson | K. J. Judiesch |
| | R. C. Brown |
| | S. W. Greenwald |
| | C. E. Hartford |
| | C. E. Radcliffe |
| | C. A. Skaugstad |
| | R. D. Whinery |
| | K. D. Dolan |
| | P. M. Seebohm |
| | K. J. Printen |
| | W. H. Baker* |
| | J. B. Wilcox* |
| Jones | A. P. Randolph |
| Kossuth | J. M. Rooney |
| Lee | G. C. McGinnis |
| | J. E. McGee |
| | R. L. Kent* |
| Linn | R. A. Sautter |
| | C. R. Aschoff |
| | R. W. Conkling |
| | R. J. Barry |
| | J. H. Lohnes |
| | A. C. Hass |
| | G. R. Wessels |
| | G. P. Hayes* |
| Mahaska | S. A. Smith |
| Marion | P. C. Todd |
| Marshall | L. O. Goodman |
| | W. T. Schultz |
| | R. R. Widner |
| Mitchell | R. G. Boeke |
| Monona | J. L. Garred |
| Monroe | D. N. Orelup |
| Montgomery | G. M. Skallerup |
| Muscatine | K. E. Wilcox |
| O'Brien | R. L. Zoutendam |
| Plymouth | J. P. Trotzig |
| Pocahontas | J. M. Rhodes, Sr. |
| Polk | D. J. Walter |
| | D. C. Young |
| | M. H. Dubansky |
| | John Hess, Jr. |
| | J. I. Fatland |
| | R. W. Overton |
| | R. L. Kollmrogen |
| | Donna Drees |
| | Marshall Flapan |
| | D. L. Sweem |
| | W. R. Hornaday, Jr. |
| | D. O. Newland |
| | Lester Beachy |
| | R. T. Brown |
| | J. J. Polich |
| | G. B. Purnell* |
| | R. I. Ortiz* |
| | J. D. German, D.O.* |
| | C. H. Denser, Jr.* |
| | B. T. Woodburn* |
| | L. O. Ely* |
| | J. W. Walker* |
| | J. L. Stecher* |
| Pottawattamie-Mills | A. L. Sciortino |
| | G. L. Neligh |
| | M. E. Olsen |
| | J. L. Knott |
| | R. K. Fryzek |
| Poweshiek | H. R. Light |
| Scott | J. C. Barker |
| | A. W. Boone |
| | W. B. Hofmann |
| | R. J. Ketelaar |
| | D. L. Miller |
| | F. W. Smith |
| | W. F. Ramsey* |
| Shelby | J. H. Spearing |
| Sioux | E. B. Grossmann, Jr. |
| Story | W. R. Bliss |
| | W. A. Baird |
| | C. J. Chapple |
| | Charles Jons |
| Tama | A. J. Havlik |
| Union-Taylor | R. H. Kuhl |
| Wapello | L. E. Coppoc |
| | R. P. Meyers |
| Wayne | K. A. Garber |
| Webster | L. K. Berryhill |
| Winneshiek | L. K. Lamberty |
| Woodbury | D. M. Youngblade |
| | D. E. Howard* |
| Worth | B. H. Osten |
| Wright | S. P. Leinbach* |
| Student IMS | D. C. Trost |

* Alternate

**LIAISON DELEGATES**

C. W. Seibert J. D. Ver Steeg

**EX-OFFICIO MEMBERS OF THE HOUSE**

R. L. Wicks
V. L. Schlaser
T. A. Burcham
J. F. Bishop
J. H. Kelley
W. V. Wulfekuhler
Hormoz Rassekh
L. D. Caraway
L. W. Swanson
Erling Larson, Jr.
J. R. Scheibe
J. R. Anderson
K. E. Lister
J. H. Sunderbruch

W. R. Bliss, M.D., Secretary of the Society, moved the minutes of the May 13, 1974 session of the House of Delegates be approved as published in the July, 1974 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. The motion passed.

Dr. Caraway introduced those individuals at the head table and welcomed delegates serving for the first time. He stressed the responsibility of the delegates to their constituents not only at the House of Delegates meeting but also as a year-round duty; he then introduced members of Reference Committees. Dr. Bliss moved the reports of the HANDBOOK FOR THE HOUSE OF DELEGATES be approved as published with the following exceptions—(1) pages 25 to 27 of Committee on Medical Education and Hospitals Report, referred to Reference Committee on Reports of Officers and Miscellaneous Business; (2) pages 31 to 32 of Subcommittee on Medical Review Report, referred to Reference Committee on Legislation and Medical Service, and (3) pages 27 to 40 of Subcommittee on Interprofessional Activities Report, referred to Reference Committee on Reports of Officers and Miscellaneous Business.

Following remarks by Dr. Wicks, IMS president, Dr. Caraway introduced Dr. Malcolm Todd, AMA president; Craig Trost, first delegate from the student IMS Component society; Charles Murfin, AMA staff member; Mrs. Arthur Austin, president of IMS Auxiliary and Mrs. Mary Louise Smith, National Chairman, Republican Party. Talks by Mrs. Smith and Dr. Todd at the morning session of the House of Delegates appear elsewhere in this issue of the JOURNAL.

★

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WESTERN IOWA OFFICE: Robert C. Schmitz, Representative
9132 Dorcas Street, Omaha, Nebraska Telephone: (Area Code 402) 393-5797
Mailing Address: Elmwood Station, Box 6076, Omaha, Nebraska 68106

# Reports of Officers
## FROM THE OFFICE OF THE SECRETARY

The Secretary of the Iowa Medical Society is responsible for maintaining membership and dues records; conducting the official correspondence, notifying members of meetings, officers of their election, and committee members of their appointments and duties; and preparing minutes of all official meetings. Assistance is also provided to the district councilors in organizing and improving the component societies, and in extending the usefulness of the IMS.

### HOUSE OF DELEGATES

Proceedings of the 1974 Annual Meeting of the House of Delegates were published in the July 1974 issue of the IMS JOURNAL. The necessary administrative procedures have occurred to implement the directives of the delegates.

District Councilors have received assistance from IMS staff in organizing their caucuses in preparation for the 1975 Annual Meeting and in preparing for the meeting of the Nominating Committee scheduled in March.

### ANNUAL SCIENTIFIC PROGRAM

The 1975 Annual Scientific Program will be in Freeport, Grand Bahama, April 3-8. A summary of the program was published in the March issue of the IMS JOURNAL. The program has been approved for 11 elective hours by the American Academy of Family Physicians.

### EXECUTIVE COUNCIL

Three meetings of the Executive Council have been held since the final session of the House of Delegates in 1974. The Council is the interim policy-making body which meets between sessions of the House to act on important issues.

### JUDICIAL COUNCIL

The Judicial Council has met three times in the past year, and a fourth session is scheduled in April. Whenever possible, the Board of Trustees and Judicial Council arrange a joint dinner prior to Executive Council sessions so that topics of general interest and concern can be discussed.

The principal responsibilities of the Judicial Council are (1) to approve applications for IMS membership; (2) to consider various questions regarding membership or ethics; and (3) if necessary, to discipline members of the Society.

A report from the Judicial Council appears elsewhere in the Handbook.

### BOARD OF TRUSTEES

Regular meetings of the Board of Trustees are held monthly and special meetings are called as necessary. The Board is responsible for conducting the business of the Society, and there is almost daily communication between IMS staff members and the President, Chairman of the Board, and other IMS Officers.

### COMMITTEES

There are 20 standing and 29 special committees of the IMS. Over 50 official meetings have been held since the House of Delegates adjourned its final session in May. Additional committee meetings are scheduled prior to the opening session of the 1975 House of Delegates.

In addition to formal committee work, staff members maintain regular contact with committee chairmen and members by telephone and personal visitation to carry out specific projects and activities.

The Society is represented on councils and committees of various state and voluntary agencies, e.g., the Iowa Regional Advisory Group, the Advisory Council to the Office for Comprehensive Health Planning, Advisory Committee on Emergency Medical Services, Advisory Committee on Physicians' Assistants Program, the Iowa Health Council, Advisory Council on Family Practice Residencies, State Drug Abuse Advisory Council, Commission to Study Nursing in Iowa, Advisory Committee for Family Nurse Practitioners, etc.

### NATIONAL, REGIONAL AND STATE CONFERENCES

The Trustees have been selective in authorizing IMS representation at national, regional and state conferences. The Trustees believe gathering and exchanging information on medical programs and issues are important and beneficial to the Society. Following is a partial listing of the major conferences at which the IMS was represented this past year: American Medical Association—Annual and Clinical Meetings; Leadership Conference; Congress on Medical Education; Rural Health Conference; National Blue Shield Annual Meeting; Blue Shield Board of Directors Meetings; North Central Medical Conference; Journal Editors Workshop; Iowa Health Council Leadership Conference; Statewide Conference on Emergency Medical Service; National Medico-Legal Symposium; Health Manpower Conference.

### IOWA REPRESENTATION AT THE NATIONAL LEVEL

Close liaison between the IMS and AMA is maintained at both the officer and staff level. Several IMS members serve on AMA Councils and Committees, including the following: D. F. Ward, M.D., Dubuque, Council on Legislation; C. H. Denser, Jr., M.D., Des Moines, Committee on Quackery; R. H. Flocks, M.D., Iowa City, Residency Review Committee-Urology; Jack Moyers, M.D., Iowa City, Residency Review Committee-Anesthesiology; B. F. McCabe, M.D., Iowa City, Residency Review Committee-Otolaryngology; Herman J. Smith, M.D., Des Moines, Council on Constitution & Bylaws; George Penick, M.D., Iowa City, Archives of Pathology; Craig Ellyson, M.D., Waterloo, Joint Commission on Health Problems in Education of NEA and AMA; Roger Simpson, M.D., Iowa City, Interspecialty Council, American Academy of Otolaryngology; Maurice Van Allen, M.D., Iowa City, Interspecialty Council, American Academy of Neurology; Scientific Section Council Officers—Paul Seebohm, M.D., Iowa City, American Academy of Allergy; Carl Graf, M.D., Iowa City, American Association of Neurological Surgeons; David Culp, M.D., Iowa City, American Urological Association; George Bedell, M.D., Iowa City, American Thoracic Society.

Donald L. Taylor, IMS Executive Vice President, a past-president of the American Association of Medical Society Executives, and three other IMS staff members,

**PEDIATRICIANS**
**INTERNISTS**
**FAMILY PRACTITIONERS**

Are you getting just a little weary of the pressures of private practice? Are there not enough hours in the day to leave anything for leisure time? Are the increasing costs of running your office and high taxes eating up your actual income? If so, why don't you consider hospital practice in one of our agencies and solve a lot of these problems.

We offer a regular work week, salaries up to $38,314 depending on qualifications and job responsibilities, additional compensation if on call time is required which may amount to as much as 20% of base salary, and an excellent fringe benefit program provided through Michigan Civil Service.

The agencies where we currently have opportunities are located in small communities where the pace of life is a little more casual and where you will be able to enjoy your leisure time in the excellent recreational facilities our state has to offer.

Why not send us a copy of your up-to-date curriculum vitae and see what can be worked out.

All applicants must possess or be eligible for a permanent license to practice in Michigan.

**Ivan E. Estes, Personnel Director**
**Michigan Department of Mental Health**
**Lewis Cass Building**
**Lansing, Michigan 48926**

AN EQUAL OPPORTUNITY EMPLOYER

are active in the AAMSE organization. Mr. Taylor has served on a special Advisory Committee to the AMA Executive Vice President; is a member of the American Association of Foundations for Medical Care (AAFMC), Task Force to Department of HEW on Professional Standards Review Organizations (PSRO); is a member of AMA Ad Hoc Committee on Federal-State Legislation. He was recently elected First Vice President of the Professional Convention Management Association and will become president in January 1976. Eldon Huston serves on the 1974-75 Nominating Committee of AAMSE, and Tina Preftakes is Program Co-Chairman for an AAMSE Regional Workshop to be held next fall.

### IMS FIELD SERVICE

Mr. Eldon Huston, Assistant Executive Vice President, directs the Provider Service Division of Blue Cross/Blue Shield, which includes both hospital and physician relations. This division includes seven physician relations representatives who maintain personal contact with physicians throughout the State and provide a valuable service to them, as well as to organized medicine and Blue Shield. The representatives operate in designated regions, and according to comments from physicians, they function effectively and provide valuable information and assistance.

### COMMUNICATIONS

The Iowa Medical Society communicates regularly with the membership to apprise Iowa physicians (1) of the many projects and programs undertaken by the Society, and (2) of its position on the numerous issues which confront medicine. Following are the communications published and/or distributed through the Society:

1. **IMS JOURNAL**—to all members; subscribers; clinical departments at the University of Iowa College of Medicine as a reference for residents, interns and medical students; also, exchange copies with other medical journals.

2. **IMS NEWS BULLETIN**—to all members, plus a selected group of allied health representatives. Bulletins reporting on IMS and AMA annual meetings are sent to all medical students at the University of Iowa College of Medicine.

3. **LEGISLATIVE BULLETIN**—to L.C.M.'s, Legislative Committee members, Executive Council, IMPAC Board of Directors, county society presidents, various allied health personnel, and to all IMS members when appropriate.

4. **IMS REPORT**—to all state and county medical society officers; to all medical students at the University of Iowa College of Medicine; to all of the previous year's graduates who are in postgraduate training in various hospitals throughout the country.

5. **IN THE PUBLIC INTEREST**—reprints to all members of the Iowa Press and Iowa Daily Press Associations; all members of the Iowa General Assembly; members of the IMS Woman's Auxiliary.

6. **WOMAN'S AUXILIARY NEWS**—to all members of the IMS Woman's Auxiliary and officers of the Society.

7. **AMERICAN MEDICAL NEWS**—to all members of the Iowa General Assembly.

8. **AMA EXECUTIVE VICE PRESIDENT'S LETTER**—to all members of the Executive Council.

### IMS MEMBERSHIP

Iowa Medical Society membership for 1974 totaled 2,352. Of this number 165 held active dues-exempt membership (93 life members, 69 residents, and 3 members in military service), and 88 associate members were exempt from the payment of dues. There were 39 counties (in 38 single or two-county societies) in which 100 per cent of the county society members held membership in the IMS. Physicians ineligible for membership numbered 77, and there were 289 eligible non-members in Iowa. The number of retired or not-in-practice physicians was 55. The percentage of eligible physicians who held IMS memberships was 89 for the year.

### COUNTY SOCIETIES HAVING 100 PER CENT MEMBERSHIP IN IMS IN 1974

| | | |
|---|---|---|
| Adair | Greene | Palo Alto |
| Adams | Hamilton | Plymouth |
| Boone | Ida | Pocahontas |
| Bremer | Jefferson | Shelby |
| Butler | Jones | Sioux |
| Cedar | Keokuk | Tama |
| Chickasaw | Kossuth | Union-Taylor |
| Clarke | Lyon | Van Buren |
| Clay | Marshall | Wayne |
| Davis | Mitchell | Winneshiek |
| Delaware | Monona | Worth |
| Emmet | Montgomery | Wright |
| Franklin | O'Brien | |

## 1974 IMS MEMBERSHIP RECORD

| Component Society | Active Members | Associate Members | Eligible Non-Members | Ineligible Non-Members | Not in Practice or Retired | Percentage |
|---|---|---|---|---|---|---|
| Adair | 1 | .. | .. | .. | 1 | 100 |
| Adams | 2 | .. | .. | .. | .. | 100 |
| Allamakee | 7 | .. | 2 | .. | .. | 78 |
| Appanoose | 6 | 2 | .. | .. | .. | 100 |
| Audubon | 2 | .. | 1 | .. | .. | 67 |
| Benton | 9 | .. | 2 | .. | .. | 82 |
| Black Hawk | 124 | 6 | 3 | 1 | 2 | 98 |
| Boone | 16 | 2 | .. | .. | .. | 100 |
| Bremer | 11 | 1 | .. | .. | .. | 100 |
| Buchanan | 13 | .. | 6 | 2 | 1 | 68 |
| Buena Vista | 10 | .. | 2 | .. | .. | 83 |
| Butler | 5 | .. | .. | .. | .. | 100 |
| Calhoun | 9 | .. | 1 | .. | .. | 90 |
| Carroll | 18 | 1 | 4 | .. | .. | 83 |
| Cass | 11 | .. | 1 | .. | .. | 92 |
| Cedar | 4 | .. | .. | .. | 1 | 100 |
| Cerro Gordo | 72 | 3 | 1 | .. | 2 | 99 |
| Cherokee | 18 | .. | 6 | .. | 1 | 75 |
| Chickasaw | 7 | 2 | .. | .. | .. | 100 |
| Clarke | 5 | .. | .. | .. | .. | 100 |
| Clay | 12 | .. | .. | .. | .. | 100 |
| Clayton | 7 | 1 | 1 | .. | 1 | 89 |
| Clinton | 25 | 1 | 20 | 1 | 1 | 56 |
| Crawford | 7 | .. | 2 | .. | .. | 78 |
| Dallas-Guthrie | 16 | 1 | 7 | 3 | .. | 71 |
| Davis | 14 | 2 | .. | .. | .. | 100 |
| Decatur-Ringgold | 7 | .. | 1 | .. | .. | 88 |
| Delaware | 7 | .. | .. | .. | .. | 100 |
| Des Moines-Louisa | 42 | 2 | 8 | .. | 1 | 85 |
| Dickinson | 6 | 2 | 1 | .. | 1 | 89 |
| Dubuque | 55 | 2 | 29 | .. | .. | 66 |
| Emmet | 12 | .. | .. | .. | 1 | 100 |
| Fayette | 12 | 2 | 5 | .. | .. | 74 |
| Floyd | 12 | 1 | 3 | .. | .. | 81 |
| Franklin | 4 | .. | .. | .. | 1 | 100 |
| Fremont | 5 | .. | 1 | .. | .. | 83 |
| Greene | 9 | .. | .. | .. | .. | 100 |
| Grundy | 4 | .. | 3 | .. | .. | 57 |
| Hamilton | 6 | 2 | .. | .. | .. | 100 |
| Hancock-Winnebago | 9 | .. | 2 | .. | 1 | 82 |
| Hardin | 13 | .. | 1 | .. | .. | 93 |
| Harrison | 5 | 1 | 1 | .. | .. | 86 |
| Henry | 9 | .. | 3 | 3 | 1 | 75 |
| Howard | 7 | 1 | 1 | .. | .. | 89 |
| Humboldt | 4 | 2 | 1 | .. | .. | 86 |
| Ida | 2 | .. | .. | .. | 1 | 100 |
| Iowa | 6 | .. | 2 | .. | .. | 75 |
| Jackson | 9 | .. | 3 | .. | .. | 75 |
| Jasper | 15 | 1 | 1 | .. | 1 | 94 |
| Jefferson | 10 | 1 | .. | .. | .. | 100 |
| Johnson | 297 | .. | 62 | 39 | 2 | 83 |
| Jones | 8 | .. | .. | .. | 1 | 100 |
| Keokuk | 6 | 2 | .. | .. | .. | 100 |
| Kossuth | 9 | 1 | .. | .. | .. | 100 |
| Lee | 38 | 2 | 3 | .. | .. | 93 |
| Linn | 151 | 7 | 25 | 2 | .. | 86 |
| Lucas | 3 | .. | 1 | .. | .. | 75 |
| Lyon | 4 | .. | .. | .. | .. | 100 |
| Madison | 3 | .. | 1 | .. | .. | 75 |
| Mahaska | 15 | .. | 1 | .. | .. | 94 |
| Marion | 10 | .. | 3 | 9 | 4 | 77 |
| Marshall | 46 | 1 | .. | .. | 2 | 100 |
| Mitchell | 10 | 1 | .. | .. | .. | 100 |
| Monona | 6 | 1 | .. | .. | 1 | 100 |
| Monroe | 3 | .. | 1 | .. | .. | 75 |
| Montgomery | 11 | .. | .. | .. | .. | 100 |
| Muscatine | 14 | 2 | 2 | 1 | 1 | 89 |
| O'Brien | 11 | .. | .. | .. | .. | 100 |
| Osceola | 1 | .. | 3 | .. | .. | 25 |
| Page | 17 | .. | 2 | .. | 1 | 89 |
| Palo Alto | 6 | .. | .. | .. | 1 | 100 |
| Plymouth | 10 | .. | .. | .. | .. | 100 |
| Pocahontas | 6 | .. | .. | .. | 1 | 100 |
| Polk | 341 | 13 | 29 | 13 | 6 | 92 |
| Pottawattamie-Mills | 69 | 2 | 4 | 2 | 3 | 95 |
| Poweshiek | 8 | .. | 4 | .. | .. | 67 |
| Sac | 1 | .. | 5 | .. | .. | 17 |
| Scott | 112 | 3 | 9 | .. | 1 | 93 |
| Shelby | 8 | .. | .. | .. | .. | 100 |
| Sioux | 13 | 1 | .. | .. | .. | 100 |
| Story | 57 | 8 | 2 | 1 | .. | 97 |
| Tama | 7 | .. | .. | .. | .. | 100 |
| Union-Taylor | 12 | .. | .. | .. | .. | 100 |
| Van Buren | 2 | .. | .. | .. | .. | 100 |
| Wapello | 35 | .. | 1 | .. | 4 | 97 |
| Warren amalgamated with Polk | | | | | | |
| Washington | 6 | .. | 2 | .. | .. | 75 |
| Wayne | 2 | .. | .. | .. | 1 | 100 |
| Webster | 50 | .. | 1 | .. | 2 | 98 |
| Winneshiek | 13 | 1 | .. | .. | .. | 100 |
| Woodbury | 109 | 4 | 3 | .. | 5 | 97 |
| Worth | 3 | .. | .. | .. | 1 | 100 |
| Wright | 15 | .. | .. | .. | .. | 100 |
| Student IMS | 15 | .. | .. | .. | .. | .. |
| TOTALS | 2,264 | 88 | 289 | 77 | 55 | 89 |

## REPORT OF THE TREASURER

The following financial statements reflect the fiscal status of the Iowa Medical Society as of December 31, 1974. The 1974 income exceeded expenses by $66,792.63.

### IOWA MEDICAL SOCIETY
*Balance Sheet—December 31, 1974*

ASSETS

| | | |
|---|---|---|
| Current Assets: | | |
| IMS Checking Accounts | | $ 15,107.41 |
| Pension and Disability Insurance Due from Employees | | 269.36 |
| Investments | | 85,403.78 |
| Short-term Investments | | 300,000.00 |
| Accounts Receivable | | 18,750.00 |
| Prepaid Expenses | | 9,320.00 |
| TOTAL CURRENT ASSETS | | $428,850.55 |
| Fixed Assets: | | |
| Land | | $ 74,216.96 |
| Building | $308,264.76 | |
| Office Furniture & Fixtures | 39,099.28 | |
| Less: Reserve for Depreciation | $242,565.00 | $104,799.04 |
| Net Fixed Assets | | $179,016.00 |
| TOTAL ASSETS | | $607.866.55 |

LIABILITIES AND NET WORTH

| | | |
|---|---|---|
| Liabilities: | | |
| Accrued Personal and Property Tax | | $ 14,000.00 |
| Deferred Compensation | | 85,403.78 |
| Deferred Income | | 315,000.00 |
| Accrued Salaries | | 1,000.00 |
| Dues to Employees | | 4.02 |
| Net Worth: | | |
| TOTAL LIABILITIES | | $415,407.80 |
| Net Worth: | | |
| Balance 1-1-74 | $125,666.12 | |
| Add: Net Excess of Income over Expenses 12-31-74 | 66,792.63 | |
| Balance Net Worth | | $192,458.75 |
| TOTAL LIABILITIES AND NET WORTH | | $607,866.55 |

IOWA MEDICAL SOCIETY
STATEMENT OF INCOME AND EXPENSES
For the Year Ended December 31, 1974

| | |
|---|---|
| Income for the Year 1974: | |
| Dues—State Society | $409,485.00 |
| Interest and Dividends on Investments | 14,877.17 |
| Miscellaneous | 746.61 |
| AMA Collection Commission | 1,827.25 |
| Building Rental and Services | 1,200.00 |
| TOTAL INCOME | $428,136.03 |
| Expenses for the Year 1974: | |
| Annual Scientific Meeting (Net) | $ 842.61 |
| Council Expense | 3,826.98 |
| County Society Services | 5,818.33 |
| Depreciation—Building & Equipment | 39,000.00 |
| Dues and Subscriptions | 2,093.36 |
| Employee Pension, Disability, & Health Programs | 16,846.32 |
| Field Service | 14,718.67 |
| General Administrative Expense | 3,056.98 |
| House of Delegates | 4,616.51 |
| Insurance | 3,101.01 |
| Journal (Net) | 19,638.44 |
| Legal Services | 10,692.50 |
| Lights, Gas, and Water | 5,629.90 |
| Office Stationery and Supplies | 6,511.06 |
| Postage | 7,667.69 |
| Repairs & Maintenance | 10,281.33 |
| Salaries | 121,532.15 |
| Service Contracts—Machines | 1,396.55 |
| Taxes: | |
| Personal & Property | 11,393.10 |
| Social Security & Unemployment | 8,004.13 |
| Telephone & Telegraph | 9,405.88 |
| Travel—Officer | 18,455.36 |
| Travel—Salaried Employee | 12,237.69 |
| Trustee Expense | 3,157.53 |
| Woman's Auxiliary | 7,915.28 |
| Committee Expense | 13,504.04 |
| TOTAL EXPENSE | $361,343.40 |
| Net Excess of Income over Expenses for 1974 | $ 66,792.63 |

THOMAS A. BURCHAM, M.D., *Treasurer*

## BOARD OF TRUSTEES

The Board of Trustees conducts the business affairs of the Iowa Medical Society, and also oversees the many projects which are implemented by committees and staff as a result of policy decisions and directives of the House of Delegates. The Board meets once each month in order to carry out its duties and responsibilities.

An up-to-date summary of Society finances and activities will be presented to the House of Delegates at the opening session of its Annual Meeting, Wednesday, April 30, 1975.

JAMES F. BISHOP, M.D., *Chairman*

## REPORT OF THE JUDICIAL COUNCIL

The Judicial Council has held three meetings since the 1974 House of Delegates. The Council has routinely handled all matters relating to IMS membership, which is one of its basic responsibilities under the Articles of Incorporation and By-Laws.

Through the course of the year, the Judicial Council and the individual councilors are called upon to resolve many situations relating to the ethics of the medical profession. Most often these questions arise through a misunderstanding between physicians or between a physician and his patient. As "peace makers" for their respective districts, the councilors are successful in almost all instances in handling problems without referral to a formal meeting of the Judicial Council.

During the past year the AMA Judicial Council clarified its position regarding physicians charging an interest or service charge on over-due accounts. The AMA Judicial Council policy is as follows:

*"Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable to medicine. It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note for professional services not paid within a prescribed period of time nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.*

*"It is not improper, however, for a physician to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time. Patient must be notified in advance of the existence of this practice."*

The IMS Judicial Council has noted that some physicians are considering the concept of some type of reimbursement for over-due accounts and encourages every doctor to be aware of the position of the AMA and the IMS on this matter.

Upon request of the Judicial Council, IMS legal counsel was authorized to draft a legal opinion on the new Iowa consumer credit code as it pertains to physicians. A summary of the opinion was mailed to all physicians in a News Bulletin. The detailed opinion is available upon request.

During the past year, the representatives of the Judicial Council met with University of Iowa medical students in a continuing effort to organize the Student Iowa Medical Society. As a result of these efforts, the 1975 House of Delegates will for the first time include a voting medical school delegate.

Two additional items that have often been discussed by the Judicial Council involve (1) telephone directory listings for physicians, and (2) relations between physicians and pharmacists. The Council has on several occasions, both individually and collectively, consulted with individual doctors, county medical societies, and other organizations to clarify matters regarding proper telephone listings and relations with pharmacists.

An additional responsibility of the Judicial Council is arranging for district caucuses in preparation for the IMS Nominating Committee meeting. The 12 district caucuses were held during February and provide an opportunity to discuss future leadership for the IMS in addition to considering resolutions that might be appropriate for review by the House of Delegates at its April, 1975 meeting.

J. E. TYRRELL, M.D., *Chairman*

# Reports of Standing Committees

## COMMITTEE OF ARTICLES OF INCORPORATION AND BY-LAWS

As of the publication date of the 1975 HANDBOOK FOR THE HOUSE OF DELEGATES, the Committee on Articles of Incorporation and By-Laws has nothing to report. If amendments are proposed prior to the Annual Meeting, the Committee will develop them for presentation to the House of Delegates.

K. J. JUDIESCH, M.D., *Chairman*

## REPORT OF GRIEVANCE COMMITTEE

The number of cases referred to the Grievance Committee this past year is the lowest in recent years. All cases were settled satisfactorily except one referred to the Judicial Council.

S. E. ZEFFREN, M.D., *Chairman*

## COMMITTEE ON HEALTH EDUCATION

The Committee on Health Education continues to promote health related programs over Iowa radio and television stations. The Society has maintained close liaison with officials at WOI and WOI-TV, and these stations frequently call for assistance in securing participants for radio and television programs on medical-socio-economic subjects.

The headquarters office also responds to numerous requests from students and lay organizations for brochures, pamphlets, and films on various medical topics. Although the IMS does not maintain a film library, the AMA is able to provide films on a variety of subjects.

Your Committee chairman continues to serve on the Joint Committee on Health Problems in Education of the American Medical Association and National Education Association. This is a coordinating and liaison body which affords physicians and educators the opportunity to confer on matters related to the health of children and youth. It reviews problems with medical and educational implications, and its pronouncements and resolutions have been used effectively to guide development of school health programs.

The Committee is available to assist county medical societies with special health education programs for use in the schools, or in the mass communications field.

C. D. ELLYSON, M.D., *Chairman*

## NECROLOGY COMMITTEE

The following members of the Iowa Medical Society died during 1974:

| | *Age* |
|---|---|
| Oscar Alden, Red Oak | 65 |
| A. Erwin Berry, Oelwein | 67 |
| Melvin H. Bloom, Des Moines | 49 |
| Richard W. Driver, Waterloo | 67 |
| John O. Eiel, Osage | 73 |
| Valiant D. French, Waukegan, Illinois | 84 |
| Harold O. Gardner, Waterloo | 75 |
| Earl E. Gingles, Onawa | 79 |
| Ingebrecht C. Jerdee, Clermont | 87 |
| John E. Kimball, West Liberty | 88 |
| Bernard C. Luehrsmann, Dyersville | 68 |
| Charles P. McHugh, Fort Lauderdale, Florida | 88 |
| William S. Markham, Harlan | 53 |
| George S. Marquis, West Des Moines | 82 |
| Francis W. Morgan, Ottumwa | 52 |
| Leonard Nelken, Clinton | 59 |
| Francis B. O'Leary, Spirit Lake | 69 |
| Carl E. Sampson, Creston | 79 |
| Adrian J. Schroeder, Marshalltown | 67 |
| Leo B. Sedlacek, Cedar Rapids | 77 |
| Kwang Hi Shin, Des Moines | 38 |
| Lawrence D. Smith, Des Moines | 79 |
| Robert J. Smith, Stacyville | 47 |
| John T. Strawn, Vinton | 93 |
| Clyde E. Thomas, Croton-on-Hudson, New York | 91 |
| Thomas L. Vineyard, Ottumwa | 88 |
| Frederick L. Wahrer, Marshalltown | 86 |
| Keith W. Woodhouse, Cedar Rapids | 65 |
| Sarah U. Wykoff, Des Moines | 77 |

## COMMITTEE ON LEGISLATION

The year 1975 promises to be another active one in both the U. S. Congress and the Iowa General Assembly.

Nationally there are several issues of major importance to the medical profession.

*National Health Insurance*—Most "experts" predict the passage of NHI. The questions in most minds are when and in what form. There are many NHI proposals in existence which vary significantly in range and scope. Some NHI plans would share expenses with the patient while others would pay all medical bills in full. In still other plans, the patient would pay according to his financial ability.

In an attempt to provide the maximum medical input into NHI, the American Medical Association will introduce a NHI bill to the Congress in 1975.

The AMA bill will emphasize certain basic principles, among which are:

1. Minimum federal involvement in administration.
2. State jurisdiction over the licensure of physicians and regulation of insurance.
3. Minimum federal dollars in the financing of comprehensive coverage for the least possible cost.
4. Funding through federal revenues, state, and private funds including:

a. Employer/employee contributions for private health insurance.

b. An individual tax credit as applied for full health care protection.

5. No added social security tax for financing.
6. No social security administration of N.H.I.
7. Cost sharing by participating individuals and families and a subsidy for the indigent scaled to income.
8. Use of private insurance on a risk underwriting basis.
9. Comprehensive coverage, basic and catastrophic, for the entire population.
10. Pluralism in methods of health care delivery.
11. Appropriate cost control.
12. Appropriate quality control.
13. Continuity of benefits.
14. Coordination of benefits.
15. Separation of professional and institutional accounting.

*The National Health Planning and Resources Development Act*—A significant change in health planning has come about with the signing by President Ford of House File 16204 which created Public Law 92-641, The National Health Planning and Resources Development Act. The AMA strongly opposed the legislation and has indicated it will institute court action in an effort to prevent implementation.

The new law will create a National Council on Health Planning and Development which will be responsible for developing "The National Health Strategy" with similar agencies at the state level called "State Health Planning and Development Agencies."

There will also be state development of "Health System Agencies" and "Health Service Areas."

The timetable for all actions relating to P.L. 93-641 reflect a sense of urgency on implementation of the law.

Each governor is to notify the Secretary of HEW within 30 days of the signing of the bill (February 4) that the Selection Process for Health Service areas has been initiated. Within 120 days (May) they are to submit proposed HSA boundaries. Within 210 days the Secretary of HEW will publish these areas in the Federal Register. Within one year HSA's are to encompass the nation. It will be necessary under this federal law for the Iowa Legislature

to pass accompanying "certificate of need" legislation. The IMS is actively following the development of the program, particularly as it relates to the designation of a Health Service Area or Areas.

*Health Manpower*—Health manpower bills were introduced and passed in each chamber of Congress. Several sections within each bill would have (1) obligated medical graduates to serve two years in various areas of need, and (2) designated the number of medical specialty residencies. The controversy regarding the impact of such legislation upon medical education and health care delivery delayed and ultimately terminated action upon these programs.

The AMA opposed the mandatory service requirements for graduates, federal control of residency training programs, and federal licensure requirements.

*PSRO*—The AMA drafted legislation to amend the PSRO law in 19 specific areas. These amendments would provide more flexibility in the PSRO law and allow more local latitude to practicing physicians. They would lessen the degree of federal intervention and control.

The AMA will introduce a similar bill into this session of Congress.

*Maximum Allowable Cost Drug Plan* (Dept. of HEW) —Under this regulatory program a maximum allowable cost would be established for similar drugs available from two or more manufacturers. Under Medicare, Medicaid and other federal programs, reimbursement would be limited to the lowest priced brand unless a physician certifies a therapeutic need for the higher priced brand.

The AMA believes that "such regulations would place the pharmacist between the physician and his patient; would require the pharmacist to substitute lower priced drugs with or without the physician's permission; would raise liability questions for physicians and would have the effect of establishing a national formulary."

The AMA position is that bioequivalence of pharmaceuticals cannot be proven and that the physician is in the best position to select appropriate drug manufacturers and drugs for his patient. The AMA has strongly opposed implementation of these MAC regulations and has threatened court action if the regulations are implemented.

*State Legislative Efforts*—The IMS Committee on Legislation has selected several priority items for support.

*Professional Liability*—Every Iowa physician is aware of the acute situation that exists relative to professional liability coverage.

The Iowa Medical Society Committee on Legislation is working closely with the IMS Medico-Legal Committee in taking positive steps to provide relief. The emphasis is necessarily directed toward the short-term problem, but the proposed measures do provide a basis for long-range solutions.

To date six bills have been drafted for introduction into the Iowa Legislature:

1. *Limitation on contingency fees*—This bill would allow for reasonable remuneration for an attorney who handles a malpractice suit but would scale the percentage of his fee as the award increases.

2. *Statute of Limitations*—Under present Iowa law the alleged injured party has two years from discovery to initiate action on medical malpractice. The IMS bill would continue to allow an adequate period for the injured party to initiate action, but would change the law to read that suit must be brought: "within two years after the date on which the claimant knew or through the use of reasonable diligence should have known or received notice in writing of the existence of injury or death for which damages are sought in the action, which ever of such dates occurs first, but in no event shall such action be brought more than four years after the date on which occurred the act or omission or occurrence alleged in such action to have been the cause of such injury or death."

3. *Proof of alleged negligence*—No suit shall be brought based upon alleged negligence unless expert testimony is presented to establish:

a. the accepted standard of care by the profession and the specialty thereof;

b. the defendant acted or failed to act with less than ordinary care in accordance with such standards in the specific circumstances of the case; and

c. that as a proximate result thereof the plaintiff suffered injury or death which would not have otherwise occurred.

4. *Elimination of the ad damnum clause*—The amount of money damages demanded shall not be stated in the petition, or original notice, or in any counterclaim or cross petition.

5. *Liability of health care providers*—A consent in writing to any medical or surgical procedure or course of procedures would specify the known risks, reactions, body damage, or disfigurement along with the probability of each such risk if reasonably determinable.

Such written and signed consent by the patient, or in the absence of the patient's legal capacity to consent, the signed consent of his legal representative would be valid and effective.

6. *Collateral Source*—Present malpractice suits most often include medical and hospital expenses incurred in the course of an illness or accident, even though the patient has been reimbursed for these expenses by his hospital and health insurance coverage. This bill would prohibit the inclusion of such previously reimbursed amounts.

*The Family Practice Residency Program Appropriation* —The IMS had a significant input into the request to the Governor for an increased appropriation for the Family Practice Program. The IMS will continue to support an adequate appropriation.

*Continuing Medical Education Authority to the Board of Medical Examiners*—The IMS supports permissive legislation which would give to the Board of Medical Examiners authority to relate CME to a physician request for license renewal with the appropriate flexibility in the application of such CME requirements.

*Legal Immunity for Physicians Serving Peer Review Functions*—The IMS role in this area is one of support. The Iowa Dental Association has indicated it will see that a bill is introduced on this subject and this effort will be supported by the IMS.

*Radiology Control*—The Committee on Legislation will be alert and responsive to any legislation in the field of radiology control.

The preceding priorities constitute the basic positive support items selected by the Committee on Legislation. Defensively, there are many flanks which need to be closely observed. The obvious ones pertain to legislation broadening the scope of chiropractic and attempted legislation to encroach on the traditional physician choice of drug management for his patient.

The IMS Committee on Legislation monitors all bills that are introduced into the House or Senate to determine their effect on the practice of medicine.

It should be emphasized this is a team effort. There are more than 100 important team members outside the Committee whose efforts are vital to the success of the legislative effort. These are the Legislative Contact Men. The LCM's are a select cadre of physicians who are personally

acquainted with their legislators. These LCM's are asked to maintain and strengthen this personal relationship and stand ready to make contacts with regard to specific legislation, bills or amendments. The personal contact of these individuals is the factor that determines what issues relating to medicine will be enacted or defeated.

DONALD C. YOUNG, M.D., *Chairman*

## COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

*Bracketed portion of this report was referred to Reference Committee on Reports of Officers and Miscellaneous Business.*

[In accordance with a previous action of the House of Delegates, the Committee on Medical Education and Hospitals has developed a document entitled "Guidelines and Procedures for Continuing Medical Education Accreditation." If this accreditation program is approved by the AMA Council on Medical Education, and if the House of Delegates authorizes the implementation of the plan in Iowa, the Iowa Medical Society will be officially designated to accredit continuing medical education programs in Iowa, specifically those of (1) hospitals which have CME activities limited to hospital staff and physicians in the local community; (2) medical organizations which do not have national scope—e.g., county or other local societies; (3) local units of voluntary health organizations not under national administration for their continuing medical education; (4) other organizations and institutions which sponsor or promote continuing education for physicians, essentially local in nature.

Under this program, local institutions accredited by the IMS would be considered fully accredited by AMA standards, and would be included in the annual listing of AMA accredited institutions. A program accredited for CME will provide the participating physician credit toward the achievement of minimal requirements to be eligible for Category I of the AMA Physician's Recognition Award, and may satisfy compulsory education requirements of medical societies and licensing authorities.

The principles set forth in the guidelines developed by the Committee represent a general statement of criteria to be used by the IMS in evaluating the quality of continuing medical education efforts of appropriate institutions and organizations in Iowa. Emphasis is placed on the following:

1. Adequate qualified leadership (acceptable to the hospital medical staff), and a strong (institutional) commitment in favor of continuing education.
2. A written set of objectives indicating what the continuing education program or programs hope to accomplish to improve physicians' competence, performance, and patient care.
3. A realistic budget.
4. A competent teaching staff.
5. A curriculum of suitable breadth and depth for the institutions' patient mix, based on identified patient needs.
6. Suitable participative educational methods.
7. Adequate facilities for continuing education with suitable audio-visual aids.
8. Some method of audit or quality of care evaluation to determine if the continuing education program for physicians has accomplished its goal.

Appropriate institutions and organizations will be invited to apply to the IMS if they are interested in seeking accreditation for their CME programs. The Committee has prepared a pre-survey questionnaire form, along with a listing of guidelines and interpretations for accrediting CME activities of hospitals and other institutions and organizations.

An institution that applies for accreditation will first be requested to complete the pre-survey form which has been designed to inventory the educational resources and activities of the applicant. The information provided will be reviewed by the Committee, or a subcommittee, and if the institution appears to meet the guidelines and essentials outlined by the Committee, an on-site visit will be made by a survey team. Each member of the Committee will serve on a survey team, and other physicians, including those experienced in medical education, will also be trained to assume this responsibility. The survey team will make a recommendation regarding accreditation, and the subsequent decision will be made by the Committee.

If accreditation is denied, the institution may appeal in writing to the Committee, with supporting information and data, requesting reconsideration.

A certificate of accreditation shall be provided to an approved institution. The accreditation will fall into one of the following categories:

1. Accreditation of the total CME program for up to four years.
2. Accreditation of the institution or organization contingent upon stipulated changes in the program. (This classification applies where the program does not meet the requirements for accreditation, but seems to have the potential for doing so; would be for a limited time only; and a re-survey would be made within a stated period of one or two years.)
3. Provisional accreditation of an institution or organization (and applicable only to newly developing programs and with a time limit of one to two years).
4. Non-accreditation of the institution or agency—in such cases, reasons for this recommendation will be given.

A survey registration fee of $100 will be charged by the IMS for administrative work connected with site visits. This shall be paid in advance at the time the pre-survey questionnaire is submitted. If no survey is indicated, the fee will be refunded. The expenses of the site visitors, to include travel and food, will be covered by the institution applying for accreditation. These expenses will be based upon actual cost, as determined following the site visit, and billed to the institution by the IMS. It is anticipated that no institution will have to pay more than $250 for a site visit, in addition to the registration fee to the IMS.

The Committee on Medical Education respectfully requests the House of Delegates to approve the proposed Continuing Medical Education Accreditation Program, as outlined above, and pending authorization by the Council on Medical Education of the American Medical Association, to implement the program in Iowa. Representatives of the Committee will be available at the appropriate reference committee hearing at the time of the House meeting, April 30-May 1, to answer any questions and to provide supplemental information, including copies of the specific guidelines and pre-survey questionnaire form.]

On January 8 representatives of the Committee and the Board of Trustees met with members of the State Board of Medical Examiners to discuss possible working relations between the Society and the BME, in light of proposed legislation concerning the establishment of continuing education requirements for re-registration of state medical licenses. In this regard, the Interim Study Committee on Professional and Occupational Licensure of the Iowa Legislature has developed a report for consideration by the Sixty-sixth Iowa General Assembly, including a recommendation that, since each professional and occupa-

tional licensing board is best equipped to determine initially what, if any, continuing education requirements are appropriate, each board should be granted statutory flexibility to make this initial determination.

At the meeting in January, it was reported that although the BME supports the permissive character of the Study Committee's recommendations, it has not as yet considered exactly how CME requirements might be established, and how a program might be administratively implemented. It is anticipated that representatives of the Committee on Medical Education & Hospitals and Board of Trustees will continue to meet with the Board of Medical Examiners as often as necessary to consider CME developments and concerns. The IMS will also keep apprised of legislative actions, and will support permissive rather than restrictive legislation concerned with continuing education requirements.

Two members of the Committee attended an AMA Conference on CME last October. A major point of agreement among the conferees in attendance concerned the use of "medical audit" as an important and primary method of determining CME needs.

The IMS served as a co-sponsor of a TAP Institute (for hospital trustees, administrators and physicians) last November in Des Moines. The program was conducted by the Joint Commission on Accreditation of Hospitals, and was concerned primarily with quality assurance programs in hospitals.

CARL R. ASCHOFF, M.D., *Chairman*

## COMMITTEE ON MEDICAL SERVICE

While the activity of the Committee on Medical Service has been minimal in recent years, the Iowa Medical Society nonetheless has been heavily involved in those programs and activities which affect the delivery of medical service.

A noteworthy achievement of the Iowa medical profession has been the development of the Iowa Foundation for Medical Care. The Foundation was created in 1971 and has become well-known and respected in the State for its peer review capability. The Foundation's current efforts to obtain conditional designation as the Professional Standards Review Organization (PSRO) in Iowa have been extensive and deserve notation. The medical profession has the opportunity to provide leadership in the implementation of the PSRO law and the Foundation, on instruction from the IMS House of Delegates, is working toward this end on behalf of the profession.

Alternate approaches to the delivery of medical service continue either under study or in various experimental or pilot stages. Indications are that a health maintenance organization (HMO) may become operative in southern Iowa in the reasonable future. The Gilfillan Clinic in Bloomfield is providing medical leadership in this HMO project.

National health insurance continues to be widely discussed and appears likely to emerge in some form within the reasonable future. A statement on this subject was accepted by the IMS Board of Trustees and presented to the Executive Council January 30. The statement appears in the March issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Various inquiries have been received from member physicians during the course of the year relating to the delivery of medical services and efforts have been made to respond. Interest continues to be expressed in the Health Insurance Claim Form developed by the American Medical Association and the Health Insurance Council. This form is universally applicable to third-party programs and is worthy of consideration by all physicians.

J. K. MACGREGOR, M.D., *Chairman*

## SUBCOMMITTEE ON MEDICAL REVIEW

The Subcommittee on Medical Review has held two meetings since the 1974 House of Delegates session and plans a third meeting some time prior to the 1975 House meeting. The Committee has dealt with several important topics.

The IMS Executive Council has approved recommendations of the Committee on several matters and has requested additionally that one item be referred to the House of Delegates with a recommendation for adoption. This report will deal with the major items considered by the Committee in order that the House members may be adequately informed.

**IMS-BS GUIDELINES USUAL, CUSTOMARY, AND REASONABLE.** The Executive Council approved in principle a statement drafted by the Subcommittee on Medical Review entitled, IMS-BLUE SHIELD GUIDELINES FOR USUAL, CUSTOMARY, AND REASONABLE FEE PROGRAMS. These guidelines set forth the understanding between the Medical Society and third parties relative to the administration of UCR. The availability of this document will be helpful to both the medical profession and third parties when problems arise regarding the UCR program. The document can be revised or clarified as appropriate when interpretations of UCR are modified.

**SPECIAL LISTINGS.** Existing IMS policy calls for listing a physician in a major specialty area on the following basis: (1) Board certified; (2) Board qualified; (3) Limits his practice to that specialty (over 50% and so recognized by his colleagues). Although there is disagreement with this policy, it has been reviewed on several occasions and has been determined to be realistic and acceptable for Iowa.

Some physicians whose practice is limited to a subspecialty have raised questions regarding the specialty categories used by the Iowa Medical Society in dealing with third parties. The Subcommittee believes that physicians in subspecialties will in fact establish their own fee profiles for specific medical services since they will be the physicians most often performing the services involved in that subspecialty. The Executive Council has reaffirmed the following categories which are in accordance with AMA recognized specialties.

1. Allergy
2. Anesthesiology
3. Colon & Rectal Surgery
4. Dermatology
5. Family Practice and General Practice
6. Internal Medicine
7. Neurological Surgery
8. Neurology
9. Obstetrics-Gynecology
10. Ophthalmology
11. Orthopedic Surgery
12. Otorhinolaryngology
13. Pathology
14. Pediatrics
15. Physical Medicine and Rehabilitation
16. Plastic and Reconstructive Surgery
17. Psychiatry
18. Radiology
19. Surgery
20. Thoracic Surgery
21. Urology

**SURGICAL TREATMENT FOR OBESITY.** Based on a comprehensive review by a special *ad hoc* committee, the Iowa Medical Society has updated its guidelines for the surgical treatment of obesity which were first established in July, 1972. Following the action of the Executive

Council, the Subcommittee was requested again to evaluate the guidelines in view of questions raised by certain physicians. The Committee will be meeting to discuss the guidelines for surgical treatment of obesity prior to the House of Delegates and if additional recommendations are forthcoming, they will be presented to the House in a supplemental report. The existing guidelines as adopted by the Executive Council follow:

A. A complete psychiatric evaluation and consultation to determine patient motivation and intellectual capacity for success in long-term follow-up.

B. A complete medical workup, consultation, *and evaluation for the need of surgery.*

C. The patient should be at least 25 years of age, with the exception of those who have compelling complications of obesity such as skeletal problems, severe heart conditions, or diabetes. In cases where obesity surgery (intestinal bypass) is deemed necessary, the procedure, felt currently to be purely experimental, should be done only in a university medical center until such time as long-term follow-up reports are available.

D. Patient's weight should be at least two times the ideal weight according to the mean weight of the medium frame on the metropolitan weight scale. The patient should have been at this weight for at least five years and *refractory to medical therapy* for at least three years.

*Bracketed portion of this report was referred to Reference Committee on Legislation and Medical Service.*

[**AVAILABILITY OF CUSTOMARY FEE DATA.** The 1974 House of Delegates adopted a resolution requesting that third party Customary Fee Data be widely available to physicians upon request. In response, the Blue Shield Medical Advisory Committee suggested that a special IMS committee be created to consider all ramifications of the proposal before a recommendation was submitted to the BS Board of Directors; subsequently, a committee was appointed comprised of representatives from the Subcommittee on Medical Review, the Iowa Foundation for Medical Care, the Blue Shield Medical Advisory Committee and the Polk County Medical Society. As a result of its deliberations, the Committee noted eight specific reasons why release of Customary Fee Data would not be in the best interest of physicians. The Polk County representative on the study committee indicated the main purpose of the resolution was to assure "credibility," and the Subcommittee on Medical Review is of the opinion that "credibility" can be assured by the IFMC. The eight reasons follow:

1. The Iowa Foundation for Medical Care is the only agency, other than Blue Shield, with access to the Blue Shield profiles. The profiles are confidential, with access being limited to organizations of the medical profession.

2. Distribution of fee profiles would result in a tendency for physicians' fees to be raised to an inflexible fee ceiling.

3. The availability of fee profiles could influence physicians to charge a fee based on the profile, rather than a fee based on physicians' voluntary decision.

4. The availability of fee profiles could not be limited to the medical profession and would soon be available to all employers and the public media.

5. If a fee ceiling were established and physicians did tend to move toward that ceiling, this could unduly increase the cost of medical care to the detriment of both the physician and his patient.

6. UCR, with its annual update of customary, responds to the actual increases in physicians' charges, whereas a fee schedule would be subject to negotiation based on many additional factors, such as public attitude, cost of living index, etc.

7. The release of customary fee data would set a precedent that could have unfortunate ramifications for the profession and Blue Shield.

8. The Iowa Foundation for Medical Care presently uses customary fee data in its peer review activity and affirms the validity or invalidity of profiles based on its review.

In taking action on this matter, the Executive Council directed that the following recommendations of the Subcommittee on Medical Review be referred to the House of Delegates when it meets in April, 1975, with the recommendation that they be adopted:

A. *That Customary Fee Data not be made available to physicians upon request, but only to the Iowa Foundation for Medical Care which would continue to maintain "confidentiality" and assure "credibility."*

B. *That non-participating physicians be provided a copy of Blue Shield's "Explanation of Benefits" form as another mechanism for assuring the patient that his Blue Shield claim has been processed correctly.*]

**OTHER ITEMS.** The Subcommittee has also consulted with Blue Shield in adopting a Statewide Customary by Specialty as approved by the House of Delegates. The Blue Shield UCR program was converted to a statewide determination of customary by specialty effective September 15, 1974. The University of Iowa medical complex is still considered a separate and distinct area in accordance with past House of Delegates action.

The Subcommittee has also consulted with Blue Shield as it moves toward the implementation of the AMA-CPT coding manual, particularly to make certain that the adoption of the AMA-CPT follows existing IMS policy in relation to billing for surgery and surgical assistants.

Finally, the Subcommittee has served as a peer review appeal body where physicians wish to have a case reviewed by the Subcommittee rather than the Iowa Foundation for Medical Care. Based on an agreement between the Iowa Medical Society and the Iowa Foundation for Medical Care, the Subcommittee will also serve as a committee of the IFMC specifically in the area of updating the standards of medical care previously adopted by the Iowa Medical Society and the Iowa Foundation for Medical Care.

During the past year, the Subcommittee has dealt with topics of major importance. The makeup of the Committee, which is based on recommendations from the various specialty groups, has been most effective in assuring that all specialties within the Iowa Medical Society are consulted on matters of major importance to the entire medical profession.

R. S. GERARD, M.D., *Chairman*

## SUBCOMMITTEE ON MEDICAL PRACTICE IN HEALTH FACILITIES AND HOMES

The Committee on Medical Practice in Health Facilities and Homes has met on two occasions this year. Representatives of the State Department of Social Services, State Department of Health and the Health Facilities Association of Iowa have conferred with the Committee.

Information on Iowa nursing and custodial homes has been presented to the Committee with elaboration on the impact of governmental funding on these facilities. There are 23,000 nursing home beds in Iowa with 11,000 of them occupied by Medicaid recipients. Approximately 53% of the 71 million dollar Iowa Medicaid budget is expended

for nursing home care. Only 9 to 10% is taken for physicians' services.

The Committee has concluded that Iowa physicians need to know as much as possible about the Intermediate Care Facilities (ICF) program. To this end, attention is called to the summary article which appears in the January issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. This report outlines the certification and re-certification procedures required of physicians. It also explains the resident care review activity required of the Department of Social Services.

Accompanying this article are six recommendations submitted to the IMS Executive Council by the Committee and approved on October 30, 1974. These call for the IMS to support (1) construction of more nursing and custodial homes, particularly in shortage areas; (2) realistic reimbursement schedules so satisfactory living conditions can be provided; (3) prudent use of health care personnel, balancing availability of funds with the need for adequate services; (4) efforts to combine required inspections to foster governmental economy and reduce the time needed for this activity; (5) and work with state agencies to increase physician understanding of the nursing and custodial home program in Iowa; and (6) stress the importance of physicians following up on their nursing home orders to see they have been implemented, and also advocate a yearly maintenance physical examination with appropriate laboratory tests for each nursing home patient, with a further strong recommendation that government pay adequately for this service when it is possible.

In addition to publication in the JOURNAL, the preceding points were contained in a news release circulated just after their approval by the Executive Council.

The Committee has volunteered to offer medical expertise to the Health Facilities Association of Iowa in its current development of a peer review program. The HFAI has 202 facilities (14,000 beds) as members. It is in the process of formulating a peer review program and in doing so has studied a Minnesota program. In preliminary discussion, the HFAI officials appear quite anxious to have IMS medical input in their emerging peer review mechanism.

The Committee has requested the chairman to develop a tentative listing of nursing home medical care guidelines for review by the Committee and the HFAI. It is possible these may be presented to the House of Delegates with a recommendation for approval and eventual distribution to the IMS membership.

In the legislative realm, the Committee has been advised of a proposal to change a portion of Chapter 135 of the Iowa Code. The change would serve to reduce the current seven classifications of homes to three, i.e., skilled nursing facility (acute care), intermediate care facility (chronic care) and residential services (assisted independent living). The Committee has transmitted to the Legislative Committee its support in principle for this reclassification legislation.

It is possible that a supplemental report may be submitted to the 1975 IMS House of Delegates.

J. F. VEVERKA, M.D., *Chairman*

## MEDICO-LEGAL COMMITTEE

On January 30, 1975, the Medico-Legal Committee presented an important report to the Iowa Medical Society Executive Council. The following paragraph served to open that report and may be used for the same purpose now.

*"The Medico-Legal Committee has followed developments in the professional liability field for several years. In this time, the State of Iowa, by comparison with other states, has presented a relatively stable picture. In the past six months, however, the professional liability market has deteriorated even further nationally, and the impact on Iowa has been greater than at any previous point. Professional liability has become one of the most pressing health care issues confronting the medical profession, federal and state governments and the general public."*

The report to the Executive Council summarized the Committee's deliberations, i.e., the conferences with insurance company officials, with the State Insurance Commissioner, with AMA representatives and with member physicians. Two recommendations set forth in the report were approved by the Executive Council and form the basis for the Society's current priority efforts in this area. The approved recommendations are as follows:

1) *That the Iowa Medical Society recognize nine legislative measures as being worthy of pursuit, and that the Legislative and Medico-Legal Committees bring these items to the attention of the Iowa General Assembly with the thought of (a) stressing the public consequences of this problem, and (b) urging the Assembly to weigh seriously the passage of some or all of these measures.*

2) *That the Iowa Medical Society enter into a formal arrangement with Rollins Burdick Hunter Company (of St. Louis) for the purpose of studying and developing a group professional liability insurance program for Iowa physicians. Emphasis in this study will be on the "captive agency" concept.*

The legislative phase of the program is in progress with six proposals in draft form. These proposals have to do with (1) establishing a reasonable contingency fee schedule; (2) modifying the statute of limitations law to a period of years from occurrence rather than two years from discovery; (3) instituting a locality provision in the use of expert witnesses; (4) eliminating the ad damnum clause to preclude the announcement of dollar levels when a suit is filed, (5) strengthening procedures pertaining to informed consent, and (6) imposing the collateral source rule to prevent payment for health care services already covered by insurance. The extent to which these items will receive favorable consideration is not known at this point.

Implementation of the second recommendation will proceed as promptly as possible and a progress report is expected to be available for presentation to the House of Delegates April 30/May. 1.

The subject of professional liability will be a principal topic at the five regional briefings to be presented for Iowa physicians during March. It is hoped a number of physicians will be present at these meetings to receive an update on this complex subject.

In concluding this brief report, it should be emphasized that the principal officers of the Society, the Medico-Legal Committee and members of the IMS administrative staff are working diligently to find both short- and long-range solutions to this problem. An effort is being made to keep the membership informed of developments as they occur.

C. H. DENSER, JR., M.D, *Chairman*

## COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations has not had occasion to meet during the past year; however, it continues to oversee the implementation of various P/R-type programs.

The "In the Public Interest" section of the JOURNAL OF

THE IMS, published each month, serves as a valuable informational tool and is prepared primarily to inform representatives of the mass communications media, and members of the Iowa General Assebly, on various issues and developments in the health field. These individuals receive reprints of the articles on a regular monthly basis. The subjects discussed this past year included professional liability, medical manpower, PSRO, family practice residencies and continuing medical education.

IMS officers and staff have provided background and resource information on various subjects of medical/socio/economic interest to reporters and editorial writers of the DES MOINES REGISTER AND TRIBUNE, and to other representatives of the mass media.

The 17th Hawkeye Science Fair will be at the Veterans Auditorium in Des Moines, April 11 and 12. This popular event is co-sponsored by the IMS, the Scanlon Medical Foundation, Drake University, and the DES MOINES REGISTER AND TRIBUNE.

The Committee urges the delegates to review carefully all of the committee reports contained in this Handbook to gain an understanding of the broad spectrum of Society projects and activities that are undertaken in an overall effort to gain public understanding and support of medicine's position on various health issues and problems, as well as to promote and assure the betterment of the public health.

J. G. THOMSEN, M.D., *Chairman*

## SUBCOMMITTEE ON INTERPROFESSIONAL ACTIVITIES

*Bracketed portion of this report was referred to Reference Committee on Reports of Officers and Miscellaneous Business.*

[Last fall, the IMS Interprofessional Activities Committee met with representatives of the Iowa Pharmaceutical Association and Blue Cross/Blue Shield to review a revised Pilot Pharmacy Project proposal to conduct a one-year evaluation of Title XIX patients in two selected Iowa communities.

The Committee acknowledges the original proposal to implement this study was rejected by the IMS House of Delegates in October 1973. At that time, concern was expressed over two provisions which would have required (1) pharmacists to be knowledgeable regarding the patient's primary diagnosis and drug idiosyncrasies, and (2) a monthly review by the pharmacist with the physician of each patient's medication history. These two requirements have been eliminated from the revised proposal.

The Committee submits to the House of Delegates the following revised proposal developed by Blue Cross/Blue Shield to carry out a one-year evaluation of Title XIX patients in two selected Iowa communities:

### PILOT PHARMACY PROJECT

Physicians in Iowa are being asked to support a Pilot Pharmacy Project developed and sponsored by Blue Cross and the Iowa Pharmacy Service Corporation. The goal of the Pilot Project is aimed at making the pharmacist an even more useful member of the physicians' health care team. More useful in terms of utilizing the pharmacists' knowledge to protect patient health and to assist the physician in drug product selection and drug use control.

The drug product selection process does not refer to the selection of a specific therapeutic agent, but relates rather to the selection of the product (brand) of that therapeutic agent. Considerable emphasis on the need for improvement in this product selection process comes from testimony by HEW Secretary Weinberger and others at recent hearings in Washington. The physician's need for drug information is becoming greater as his time to absorb that information becomes smaller.

HEW Secretary Weinberger's pronouncements about his lowest cost or generic reimbursement proposal give great impetus to the campaign to repeal state antisubstitution laws. This proposal would limit drug reimbursements under programs administered by HEW to the lowest cost at which a generic drug is generally available. Whether physicians agree with the statement of Secretary Weinberger on drug product equivalence or not, the fact is that the proposed HEW policy will limit the ability of the physician to select the product of his choice. The Pilot Project would hope to demonstrate that the pharmacist can assist the physician in the development of more effective drug product selection standards. Further, the project hopes to demonstrate that these standards can be best established at the community practitioners level rather than by some directive originating at the state or national level.

Testimony coming from recent hearings of the Kennedy subcommittee on health, committee on labor and public welfare, United States Senate, focused on some specific concerns. One of those concerns relates to the widespread misuse of drugs, particularly antibiotics. Another was the relatively large number of deaths and injuries resulting from adverse drug reactions. A recent study conducted in California reported that 7% of the ambulatory population and 22% of the confined population in nursing homes experience drug-drug interactions.

The adverse drug reaction problem is augmented by multiple drug usage on the part of patients. In order to prevent these adverse drug effects, the project proposes to make a change in the drug distribution system. That change is the incorporation of a medication record for each patient. The pharmacist, by monitoring each patient's drug therapy, can quickly identify potential problems and bring them to the attention of the physician.

#### PROJECT SUMMARY

1. Title XIX recipients in two selected counties would be required to choose a pharmacist in the area to provide their pharmaceutical services. The recipient would have the freedom to select the pharmacy of his/her choice and, as nearly as possible, will be restricted to utilizing that pharmacy for the duration of the project. There will be provisions, however, for changing of pharmacies and for utilizing more than one pharmacy.

2. Physicians in the two selected counties will be asked to participate as follows:

a. Work closely with other physicians and pharmacists in the county on the development of drug product selection standards. This would involve a review of selected, widely used, chemically equivalent products in an attempt to select those biologically equivalent or clinically equivalent products which are associated with a low cost factor.

b. Review selected Title XIX patient medication profiles on a monthly basis. The patient's medication profile is a monthly medication history for that patient. Physicians would be requested to review a copy of this monthly medication history for selected patients where potential problems re drug use might occur. Approval to continue that patient's medication regimen would be noted on the profile and forwarded to the pharmacy at the beginning of each month. This mechanism would provide the physician with a means of quickly reviewing each patient's drug history as well as a convenient means of communi-

cating with the pharmacist concerning changes in that drug profile.

3. Pharmacists in the two selected counties will participate as follows:

a. Work closely with the physicians and other pharmacists on the development of product selection standards.

b. Maintain an individual patient medication profile and monitor each patient's drug therapy. This review will involve an evaluation of each medication with respect to possible drug-drug interactions, adverse drug reactions and drug idiosyncrasies. The pharmacist will notify the physician(s) immediately in instances where such potential reactions might occur.

4. The Department of Social Services will be responsible for:

a. Providing payment to Blue Cross for pharmaceutical services on a monthly basis.

b. Providing for coordination by the County Departments of Social Services with Blue Cross relative to patient's choice of pharmacies, changes in the eligibility of Medicaid recipients and changes in provider designation.

c. Working with participating pharmacies relative to patient needs and counseling requirements which may become apparent during the course of the project.

5. Blue Cross will be responsible for all activities related to the pilot project.

The Pilot Pharmacy Project will operate in two selected counties. The project, assuming approval by IMS, will be presented to physicians and pharmacists in the selected counties. The presentation will be made in individual meetings and then in a joint session. If either one or both of the selected counties refuse participation, Blue Cross will contact substitute counties until two representative county groups agree to participate.

The Iowa Medical Society is requested to approve the general concept of the Pilot Pharmacy proposal. Approval has already been obtained from the Iowa Society of Osteopathic Physicians and Surgeons, the Iowa Pharmaceutical Association, the Iowa Department of Social Services, the Boards of Directors of Blue Cross and of the Iowa Pharmacy Service Corporation, and from the HEW Regional Office in Kansas City.

Progress reports on the project will be made at monthly intervals to all parties concerned. Changes or modifications in the project will be made only with the approval of representatives from the Iowa Medical Society, the Iowa Society of Osteopathic Physicians and Surgeons, the Iowa Pharmaceutical Association, the Iowa Department of Social Services, Blue Cross, The Iowa Pharmacy Service Corporation, and individual physicians and pharmacists participating in the project.

The Committee wishes to point out that when this proposal was reviewed in joint session last fall, concern was expressed about the establishment of a national formulary, and a push for generic prescribing and enactment of laws to permit substitution of drug products other than those prescribed or agreed upon by the physician. However, the Committee was assured it is not the intent of the project to establish a hard and fast formulary, nor to usurp the right of the physician to prescribe whatever he wishes and feels is best in any situation; also, that cooperation at the local level between doctors and pharmacists can result in cost savings and assure the quality of drug prescriptions in the community.

The study as outlined above has been approved for implementation by the Iowa Pharmaceutical Association, the Iowa Society of Osteopathic Physicians and Surgeons, and the State Department of Social Services. The House of Delegates is requested to evaluate the revised proposal, and take action on whether it should be approved by the IMS. Representatives from BC/BS will be available at the appropriate reference committee hearing to provide any necessary supplemental information, and to answer any questions posed by the delegates.]

At the joint session, there was considerable discussion concerning the prescribing of medications by physician's assistants. It was reported the Board of Medical Examiners has determined under its rules and regulations governing the utilization of PA's in a primary care setting, there will be no reference—either permissive or prohibitive—to prescribing by PA's; rather, each supervising physician will be required to submit a report outlining how he intends his PA to function and, if the PA is to prescribe, under what protocol. When such material is received, it is anticipated any information relating to prescribing by PA's will be reviewed with the State Board of Pharmacy and, if deemed desirable, an opinion from the Attorney General will be requested.

At its meeting in October, the IMS Executive Council was provided information regarding a proposed program of the IPhA to prepare questionnaires for use by pharmacists in obtaining information from M.D.s regarding prescription refill authority, and no objections were expressed to the project. Specifically, M.D.s will be requested to provide information regarding prescribing or refill authority for non-M.D. staff, office hours, procedure for calling in prescription to pharmacy, how M.D. will indicate refilling authority, etc.

In December, the Committee responded to a request of the IMS Judicial Council to review and comment on a series of articles written last fall by the late Gordon Gammack on matters concerning physician dispensing and clinic pharmacies. The articles were published in the DES MOINES REGISTER AND TRIBUNE. After reviewing the articles, and other pertinent information, the Committee agreed the profession should be reminded that a Physician-Pharmacist Code of Understanding was jointly developed and approved by the IMS and IPhA in 1959 and amended in 1963; further, there is a need to revitalize the Code and to focus attention on the provisions which are intended as guides for both physicians and pharmacists.

Members of the Committee are presently giving individual study to the Code, and a joint meeting will be held early in the Spring with IPhA representatives to review the existing document. Consideration will be given to any appropriate revisions in the guidelines, as well as a timetable for reprinting the Code for distribution to all members of the IMS and IPhA.

If revisions or amendments are proposed, they will be submitted to the appropriate policy-making bodies of the IMS and IPhA for approval.

The Committee was pleased to receive a communication announcing the creation of an Iowa Physician's Assistant Society, and will serve as a liaison with this new organization so matters of mutual interest and concern can be formally considered.

Two members of the Committee—C. E. Radcliffe, M.D., and V. H. Carstensen, M.D—continue to represent the IMS on the Board of Directors of the Iowa Health Council; in addition, Donald L. Taylor, Executive Vice President of the IMS, serves as Secretary-Treasurer of the Council. The IHC consists of the following member organizations: Iowa Dental Association, Iowa Hospital Association, Iowa Medical Society, Iowa Nurses' Association, Health Facilities Association of Iowa, Iowa Pharmaceutical Association, Iowa Podiatry Society, Iowa Society of Osteopathic Physicians and Surgeons, and Iowa Veterinary Medical Association.

On February 6, a special Leadership Conference for representatives of the member organizations was held in Des Moines. Subjects of common concern were presented —i.e., PSRO Developments; Implementation in Iowa of New Federal Health Planning Legislation; Continuing Education Requirements for Providers of Health Care; Legislative Programs of the Member Organizations.

The Leadership Conference was followed by the annual dinner sponsored by the IHC honoring members of the Iowa General Assembly and other State officials. This is mainly a social gathering, with no formal program except for a brief presentation concerning the general purpose and activities of the Council. Emphasis is placed on the fact that the IHC represents approximately 14,000 persons engaged in health care delivery. IMS staff and office facilities are utilized to coordinate and implement the various programs of the IHC.

C. E. RADCLIFFE, M.D., *Chairman*

## COMMITTEE ON SCIENTIFIC WORK

In an effort to provide members of the IMS the opportunity to participate in a combined travel/continuing medical education program, arrangements have been made to hold the 1975 Scientific Session in Freeport, Grand Bahama, April 3-8. Three full mornings of scientific presentations have been scheduled, and the program has been approved by the American Academy of Family Physicians for 11 hours of elective credit.

The program outline will appear in the March issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

RALPH L. WICKS, M.D., *Chairman*

## COMMITTEE ON STATE DEPARTMENTS

A Committee on State Departments is provided for in the organizational structure of the Iowa Medical Society as a sort of umbrella over those aspects of the Society's program which are related broadly to public health. The Committee on State Departments has six subcommittees which function on behalf of the medical profession. The subcommittees are Aging and Chronic Illness, Maternal and Child Health, Psychiatric Care, Public Assistance, Rehabilitation, and Safe Transportation.

The chairmen of these several subcommittees comprise the Committee on State Departments. And it is the purpose of the Committee on State Departments to serve as a bridge between the profession and the State Department of Health. Acknowledgement is made of three physicians who currently serve on the State Board of Health: P. M. Seebohm, M.D., Iowa City; P. J. Leehey, M.D., Independence; and E. E. Gamet, M.D., Lamoni. Norman L. Pawlewski is in his second year as Iowa Commissioner of Public Health.

Information on public health matters is published regularly in the JOURNAL OF THE IOWA MEDICAL SOCIETY and in other IMS publications.

It is possible to report that communication between the Society and the State Department of Health is good. Opinions differ at times but this has not deterred the passage of information.

A. H. DOWNING, M.D., *Chairman*

## SUBCOMMITTEE ON AGING AND CHRONIC ILLNESS

An update on the Intermediate Care Facilities (ICF) Program in Iowa was presented in the January 1975 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. This summary article stresses the need for Iowa physicians to have a working knowledge of the ICF program.

The ICF program is one of 16 services available to eligible Iowans through the Title XIX Medical Assistance Program (Medicaid). It is funded jointly by the state and federal governments with a 60% federal participation in Iowa.

A medical assistance recipient may be placed in an ICF only upon certification of a licensed physician. Knowledge on the part of the physician as to the proper placement of a patient is important. One of the following three levels of care is most likely to be selected for the patient: skilled (extended) care; intermediate (basic or intermediate nursing home), or custodial care.

Federal legislation requires physician re-certification of the need for care and services to ICF residents every 60 days. The State Department of Social Services (SDSS) has attempted to devise procedures to facilitate this process.

The SDSS is required additionally to conduct resident care reviews and evaluations of all Title XIX ICF residents. Care review teams must visit each ICF at least annually. Physician consultants are available to provide assistance to the care review teams.

Iowa physicians or county medical societies desiring information on the ICF program are invited to contact Elmer M. Smith, M.D. (515/281-3359) at the SDSS Bureau of Medical Services in Des Moines.

Attention is directed to the report of the Committee on Medical Practice in Health Facilities and Homes where reference is made to a state legislative proposal to reduce from seven to three the number of classifications for non-hospital health facilities.

E. E. LINDER, M.D., *Chairman*

## SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

Activities of the Subcommittee on Maternal and Child Health have been concentrated this year in the area of immunization. At a late summer meeting, the Subcommittee conferred with the Commissioner of Public Health and with the Director, Immunization Program, State Department of Health (SDH). Liaison and cooperative effort with the SDH and other organizations have continued through the year.

The 1974 IMS House of Delegates approved a statement dealing with the eradication of communicable diseases in Iowa. This statement was developed by the SDH, reviewed by the Subcommittee, and recommended to the House last year.

In pursuit of the disease eradication goal, the Subcommittee has invited and urged county medical societies to designate a member physician to serve as immunization chairman. Between 30 and 40 counties have named a physician to serve in this liaison capacity between the State Department of Health and the Subcommittee. A packet of background material has been sent to each chairman and further orientation activities are planned. Personal contact has been made with the county immunization chairman in instances where disease outbreaks have occurred.

Outbreaks of measles have been reported in several Iowa counties in 1975 and cooperative efforts have been undertaken to restrict any spread. It should be emphasized that SDH officials and representatives of the Subcommittee are anxious to work with local physicians and other health personnel (1) to develop immunization programs which may eliminate these outbreaks, and (2) to assist in keeping them as minimal as possible.

While immunization activity needs ongoing emphasis, various statistics are heartening and worthy of note. A school immunization survey of Iowa kindergarten/first grade pupils (81.4% response) showed the following 1974 immunization levels (1973 results in parentheses): polio (3 plus doses)—78.8 (69.8); DPT (3 plus doses)—86.2 (84.3); measles—80.2 (76.2); rubella—70.1 (71.0); mumps —57.9.

The Subcommittee expects to distribute several informational updates to the county medical societies in the next few weeks. It also is proposing to present a half-day seminar for county immunization chairmen in May.

The Society and the Subcommittee, as well as the Woman's Auxiliary, were active in the 1974 Immunization Action Month which occurred in October. Several Iowa physicians aided in this program by making radio and television interview appearances. This activity is coordinated by an Immunization Advisory Committee. The 1975 chairman of this Committee will be Mrs. E. J. Drew, who serves as a representative of the Woman's Auxiliary to the Iowa Medical Society.

Representatives of the Subcommittee have helped to revitalize the Maternal Mortality Committee this past year. This is a combined effort of the University of Iowa College of Medicine, State Department of Health and IMS. W. J. Balzer, M.D., is the chairman. The Committee will make an appraisal of the State's maternal deaths for the educational value which may derive.

The Subcommittee has continued to follow and offer comments on certain legislative proposals, e.g., revisions in the statutes pertaining to adoption, changes in the criminal code relating to feticide. Legislation was enacted in 1974 to include insurance coverage for newborns from birth.

Other matters discussed by the Subcommittee include learning disabilities among children, venereal disease, acupuncture, etc.

G. L. BAKER, M.D., *Chairman*

## SUBCOMMITTEE ON PSYCHIATRIC CARE

Five meetings of the Subcommittee on Psychiatric Care have been held during the past year. The following measures have been considered in these meetings:

1) Proposed Revision of the Iowa Civil Commitment Law. This matter has been under consideration for approximately three years. A joint committee of the Iowa Medical Society and the Iowa State Bar Association first began to evaluate those State statutes which involve hospitalization of the mentally ill. The deliberations and recommendations of this joint body were merged with the efforts of a Legislative Study Committee. Several meetings and hearings have resulted in a bill for an act relating to hospitalization of the mentally ill. The current legislation has undergone several revisions some of which are based on recommendations of the physician members of the joint IMS-ISBA committee. The bill is awaiting introduction in the Iowa General Assembly, and while it has aspects which cause some concern, overall, the Subcommittee believes it is acceptable to the medical profession and is recommending that it should not be opposed as last revised. The bill has been assigned to subcommittees of the Committees on Human Resources in both the House and Senate. A further public hearing on the bill is scheduled as this report is prepared, for March 7, 1975.

2) Other Legislative Matters. The Subcommittee has reaffirmed its historic position regarding allied or paramedical workers by opposing a bill to license social workers. The Subcommittee has also reaffirmed its position with respect to continuing the Iowa Mental Health Authority under the State Board of Regents rather than placing it under another agency of government. The Subcommittee has evaluated a legislative proposal which allocates funds directly to the counties and eliminates the 20% subsidy now given counties for treatment afforded their residents at the state mental health institutes. The consensus toward this bill was negative but the Subcommittee did not act formally.

3) Follow-up Study of Former Patients by the Legislative Study Committee on Mental Health and Juvenile Institutions. This study is in the preliminary stage and will attempt to assess patient outcomes and include a review of follow-up services provided by community mental health centers, county homes and nursing homes. Several members of the Subcommittee are active on the advisory committee concerned with this project.

4) Blue Shield. Discussions with Blue Cross/Blue Shield representatives have occurred during the year in an effort to devise new and better ways of providing benefits to psychiatric patients. Some progress has been made but no conclusive action has been taken. The coding and nomenclature of the AMA/CPT in the psychiatric area has been given endorsement. Efforts are being made to compile useful data from a private practice survey made by the Iowa Psychiatric Society. It is possible that a supplemental report on this subject will be presented to the House of Delegates.

5) Iowa Foundation for Medical Care. The Subcommittee has met with an IFMC representative to receive a briefing on Foundation peer review activity and other aspects of the Foundation program.

6) New Alcoholism Law. Representatives of the Subcommittee have met with officials of the State Department of Health and the Committee on Alcoholism to go over problems associated with the implementation of this new law.

These are among the principal matters considered by the Subcommittee on Psychiatric Care this past year.

H. L. NELSON, M.D., *Chairman*

## SUBCOMMITTEE ON PUBLIC ASSISTANCE

The Iowa Medical Assistance Program (Title XIX/ Medicaid) had 122,000 eligible recipients in 1974. The Iowa Medical Society continues to maintain liaison with the State Department of Social Services regarding this important program. Elmer M. Smith, M.D., Acting Director, Bureau of Medical Services, SDSS, and his staff are to be complimented for their effective administrative efforts.

In 1974 Iowa Medicaid paid out $58.3 million with 59.7% of this coming from federal sources and 40.3% from state funds. Of this sum, $6.1 million (10.5%) was paid to medical doctors; osteopathic physicians received just over $1 million. Other principal providers received reimbursement on the following percentage basis: inpatient hospital—18.4%; pharmacies—9.3%; intermediate care facilities—52.8% and dentistry—4.2%.

As an indication of monthly Medicaid activity, the number of Medicaid recipients who received M.D. services in December 1974 totaled 20,897 with the cost per recipient averaging $26.27. M.D. services in December included 44,935 office visits, 464 home visits, 13,166 hospital in-patient visits; 2,182 hospital out-patient visits; 3,111 nursing home visits, and 2,788 dispensed prescriptions.

The federal program of Supplemental Security Income

for the aged, blind and disabled began in 1974. It replaced the state public assistance programs of old age assistance, aid to the blind and aid to the disabled. The Medical Assistance Program provides payment for medical and health services for individuals receiving payments under SSI.

Two groups of persons are eligible for Medical Assistance: (1) those paid through SSI, and (2) certain individuals in a medical institution who meet all eligibility requirements for SSI except for income. Persons eligible for Medical Assistance are issued a Medical Assistance Identification Card by the Department of Social Services. This card is to be presented each time a contact is made with a provider of health services.

Of significance currently is the Intermediate Care Facility (ICF) program, which is one of the services available to persons eligible for Medicaid. The status of this program is summarized in an article which appears in the January 1975 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

A major responsibility of physicians in the ICF program is that of certifying applicants. A medical assistance recipient may be placed in an ICF only upon certification of a licensed physician. This certification is completed on State Department of Social Services Form MA-2130-0. Nursing homes are responsible for initiating the form. Proper placement of applicants requires a knowledge of accepted standards for levels of care. Three levels of care are prominent: skilled (extended) care; intermediate care facility (basic or intermediate nursing home), and custodial care.

Re-certification is required by physicians of Title XIX ICF residents every 60 days. To facilitate this process, the SDSS has determined that progress notes and a physician's signature on an ICF resident's chart constitutes compliance. A $3 fee is paid to physicians for each re-certification.

The SDSS is required to conduct resident care reviews of all Title XIX residents. Care review teams are now performing this function. Physician consultants have been designated in 13 of the 20 areas to advise the care review teams.

Good liaison continues to exist between the Society and the State Department of Social Services.

A. J. HAVLIK, M.D., *Chairman*

## SUBCOMMITTEE ON REHABILITATION

The Subcommittee on Rehabilitation remains on standby status and has not met this past year. Acknowledgement is made of several matters relating to the broad area of rehabilitation.

First, note is taken of the liaison now in process involving representatives of the Iowa Medical Society, the Iowa Physical Therapy Association and the Iowa Hospital Association. This discussion is for the purpose of clarifying the relationship between medicine, physical therapy and hospital administration.

Reference is also made to the Supplemental Security Income program which became operative in 1974. This SSI program replaced federal-state programs of public assistance payments to the aged, disabled and blind.

Under the SSI program heavy reliance is placed on Iowa physicians for supportive medical evidence on patients who apply for benefits. The same State agency handling the Social Security Disability Program is responsible for the development and adjudication of the SSI program. Determinations are being made as to eligibility of claimants applying for benefits.

The Social Security Program encourages persons to return to gainful employment whenever possible. At the time a person's disability claim is processed, he is considered for Vocational Rehabilitation Services. Referral to rehabilitation services is made as often as possible. Many disabled persons have been able to return to work after receiving rehabilitation assistance.

Acknowledgement is made of the service rendered by Homer E. Wichern, M.D., Des Moines, as chief medical consultant, Rehabilitation Education and Services Branch, Iowa Disability Determination Unit, Social Security Disability Program.

C. B. LARSON, M.D., *Chairman*

## SUBCOMMITTEE ON SAFE TRANSPORTATION

The chairman of the Subcommittee on Safe Transportation met last spring with officials of the Iowa Department of Public Safety to discuss matters of mutual interest and concern. Excellent cooperation and liaison exists between the Committee, staff, and representatives of the Department and the Iowa Highway Patrol.

The Medical Advisory Board to the DPS continues to review and make recommendations on medical reports required by the Department on certain drivers license applicants. There is mutual agreement that the anonymity of the Advisory Board must be maintained in order to assure its continued effectiveness and service.

Last fall, at the request of the DPS, the Medical Advisory Board considered a resolution of the Iowa Chapter of the Epilepsy Foundation of America calling for a modification of present DPS regulations to permit waiving, on an individual basis, the requirement for a one-year period of seizure-free experience as a condition for obtaining a drivers license, under specified conditions. The Board recommended continuance of the present one-year seizure-free requirement.

The Subcommittee on Safe Transportation is available to meet with all organizations and agencies interested in programs designed to reduce the number of injuries and deaths resulting from motor vehicle accidents.

A. H. DOWNING, M.D., *Chairman*

## PUBLICATIONS COMMITTEE

The JOURNAL OF THE IOWA MEDICAL SOCIETY is marking the 125th year of the Society's history by continuing to serve as the official publication. The effort continues to be made, acknowledging space limitations, to choose material for publication (both scientific and socioeconomic) which is useful and informative. The JOURNAL is recognized by those who participate in its production as both a medium of information for member physicians and a chronicle of medical history for those who will look back on this time.

The assistance provided by various persons in generating material for the JOURNAL is acknowledged with appreciation. Richard M. Caplan, M.D., is the JOURNAL's "man on the campus" and is helpful in stimulating and coordinating scientific writing from the academic community. Also, we continue to be pleased by the number of manuscripts prepared and submitted by Iowa physicians who are busy in private practices.

As is our habit at the end of these reports, we issue an invitation to member physicians to submit editorial ideas, case reports, scientific manuscripts and news items to the JOURNAL. It will be our intention in the ensuing year to provide a publication which is of interest and value to the Iowa medical profession.

MARION E. ALBERTS, M.D., *Scientific Editor*

# Reports of Special Committees

## COMMITTEE ON ALCOHOLISM

The Committee on Alcoholism has met four times during the 1974-75 Society year. The following matters have received attention during this period:

1) New State Alcoholism Law. This new law was enacted in 1974 and its implementation has caused much confusion. The intent of the law is to make the problem of alcohol a health matter and take it out of the criminal context. This has been regarded as positive by the Committee. The recent appointment of Mr. Jeff Voskans as Director, Iowa Division on Alcoholism; the apparent availability of more nearly adequate funding; and the prospect for amending some of the inappropriate sections of the new law give rise to some optimism over the future of this new Iowa alcohol program. The new Iowa Commission on Alcoholism consists of nine members and includes William McCabe, M.D., Bettendorf, who also serves on the IMS Committee.

2) Pilot Project (Waterloo/Schoitz Hospital/Northeast Council on Alcoholism). This project was initiated in January after extensive delay. The program is expected to continue in experimental form for two years. Under it, certain Blue Cross/Blue Shield subscribers who receive alcoholism rehabilitation treatment from Schoitz Hospital may receive additional benefits for outpatient alcoholic rehabilitation counseling services. BC/BS will reimburse Schoitz at a rate agreed upon for counseling services provided by NECA. Data will be gathered and evaluated to determine the merits of the program. The Committee on Alcoholism will serve as a peer review type of consultant and will provide counsel as requested.

3) Other Alcohol Programs. The Committee is following other alcohol treatment proposals which are under consideration. These involve the Lakeside program in Cedar Rapids, the Mideast Clinic in Iowa City and Broadlawns in Des Moines.

4) Liaison with Iowa Hospital Association. Factors relating to the new state alcoholism law have been discussed with representatives of the IHA. Concern over the limited medical direction which is emerging has been expressed by the IHA representatives and these matters will be pursued with Mr. Voskans and members of the Commission.

5) The 1975 Northwest Iowa Summer School on Chemical Substances and Other Addictions. The Iowa Medical Society, on recommendation of the Committee, will again serve as co-sponsor of this event. It will be offered from June 8-13 at the Iowa Lakes Community College in Estherville. The Committee is again encouraging county medical societies to sponsor the participation of a local youth in this summer program.

6) Educational Efforts. Various members of the Committee, and particularly H. F. Moessner, M.D., have been participating this past year in various workshops and seminars on alcoholism. Particularly successful was a November 20-21 conference on management of the acute alcoholic at the University of Iowa.

7) Leo B. Sedlacek Foundation for Alcohol Education. This memorial to Dr. Sedlacek is being formed and a member of the Committee will serve as chairman of the Foundation. Mr. Jeff Voskans has indicated he will provide administrative support for the program.

This report will attest to the diversified activities of the Committee which has been in existence for approximately five years.

S. M. HAUGLAND, M.D., *Chairman*

## COMMITTEE ON ALTERNATE DELIVERY SYSTEMS

The Committee has continued to function in the capacity of advisor, primarily to Blue Cross and Blue Shield, as they develop alternate delivery programs. The project in Davis County (Bloomfield) has been the primary program to which the Committee has devoted its attention. It is understood that although excellent progress has been made, the ADS is not yet prepared to market the program. The Committee may hold at least one additional meeting prior to the House of Delegates; and if more specific information is available, it will be brought to the attention of the House in a supplemental report.

The Committee has also reviewed a "Local Health Plan" which is a form of ADS wherein the concept of an "HMO without walls" is followed. This type of program has had some success in Wisconsin as administered by the Blue Shield plan of the Wisconsin State Medical Society and has been adopted by other areas. The Committee will continue to meet with Blue Cross and Blue Shield on this matter.

One final item to which the Committee has given only brief attention is a physicians' service system. This system is a billing and record-keeping program for physicians' offices and has been successfully implemented by select Blue Shield plans in the United States. Iowa Blue Cross and Blue Shield has expressed a willingness to experiment with this program to determine its applicability and acceptance in Iowa. Also, the Iowa Foundation for Medical Care has expressed some interest. If there are specific recommendations which require consideration by the Iowa Medical Society, they will be dealt with in a supplemental report.

J. F. BISHOP, M.D., *Chairman*

## COMMITTEE ON ARCHITECTURAL EDUCATION

The Committee on Architectural Education regrets that the final preparation and printing of a set of guidelines and procedures for use by individuals involved in hospital/health facility building programs has been delayed due to the press of other problems and activities of the Iowa Medical Society. However, the Committee hopes this project will be completed during the coming year.

The guidelines, which will be set forth in the form of a flow-chart, were developed in cooperation with representatives of the Iowa Chapter/American Institute of Architecture, in an effort to assure that a hospital or health facility structure will most effectively meet the needs of those who provide health care, and the recipients of that care. The guidelines emphasize that (1) there be a broad base of physician participation in the initial planning of a building venture; (2) the architect who designs the facility should have early access to and consultation with the physicians who will utilize it; and (3) there should be continuing contact between the physicians, the architect, and the facility administrator.

Officials of the Iowa Hospital Association have also been contacted regarding the guidelines and IHA officials have expressed an interest in cooperating in the printing and distribution of the document.

W. R. BLISS, M.D., *Chairman*

## COMMITTEE ON BLOOD BANKING

Representatives of the IMS Committee on Blood Banking are actively involved in the development of a coordinating agency for the State of Iowa which has been incorporated under the name of Iowa Blood Council. Orga-

nizational meetings will soon be called and representation from the Iowa Medical Society is assured, if the Society wishes to participate.

The Iowa Blood Council has been formed to cooperate with the newly forming American Blood Commission.

Further developments will be made available to the House of Delegates.

W. S. PHETEPLACE, M.D., *Chairman*

## COMMITTEE ON COMMUNITY EMERGENCY MEDICAL SERVICES

Although the Committee on Community Emergency Medical Services has not had reason to meet during the past year, it has been kept apprised of developments occurring at the state and national levels.

As announced in an IMS News Bulletin reporting on the 1974 AMA Clinical Convention, the AMA House of Delegates approved guidelines for a rural EMS system. The criteria were developed for designating a rural hospital as an emergency facility. Copies of the guidelines can be obtained from the IMS headquarters office.

Several members of the Committee attended the Statewide Emergency Medical Services Conference held in Des Moines late last March under the sponsorship of the Governor's Emergency Medical Services Advisory Council. Your Committee chairman continues to represent the IMS on the Advisory Council, and several other physicians also serve, including William R. Bliss, M.D., Secretary of the IMS.

The Advisory Council is in the process of developing an EMS Plan for the State of Iowa, and a preliminary draft of a proposed plan has been developed. The plan is necessary in order for the state to qualify for federal funding for certain transportation and EMS projects and activities. When the EMS Plan is completed, it will be submitted to the U. S. Department of Transportation and the Department of Health, Education and Welfare.

A progress report concerning the activities of the State EMS Advisory Council, and the implementation of the State EMS Plan, will be published in a future issue of the IMS JOURNAL.

A. H. DOWNING, M.D., *Chairman*

## COMMITTEE ON DELEGATION OF AUTHORITY

The Committee on Delegation of Authority has official status as the Joint MD/Nurse Liaison Committee, serving with representatives of the Iowa Nurses' Association and the Iowa State Board of Nursing. Representatives of the IMS, INA, and Board of Nursing have been meeting on a formal basis for over two years to discuss matters of common interest. Previously, the IMS and INA met on a need basis, and cooperated in the development and approval of joint statements dealing with "The Intravenous Administration of Fluids and Medications by Professional Nurses Practicing in Hospitals or Organized Agencies in Iowa," and "Nursing Functions for Registered Nurses Practicing in Hospitals or Organized Agencies in Iowa." Still under development is a statement on "Standards of Nursing Practice in Hemodialysis Units."

At a meeting of the Liaison Committee last fall, a progress report was presented on the Family Nurse Practitioner Project, which is being sponsored by the Iowa Hospital Association and IMS, with funding from the Iowa Regional Medical Program. The one-year pilot project, which began last September, is designed to train registered nurses as "family nurse practitioners" to serve in satellite medical clinics under the supervision of licensed physicians. Six nurses and six physician preceptors have been designated to participate in the pilot program. The nurses will participate in five formal training periods at the University of North Dakota, and between each phase they will work directly with their assigned preceptors.

The ultimate goal of the demonstration project is to determine whether the use of the nurse practitioner, as a new category of health manpower, can help to increase the availability of primary health care services in rural Iowa. It is emphasized that under the FNP program, the nurse will serve within an organized health system, under the supervision of a physician, and she will carry out dependent, interdependent, and independent functions; she will not be an independent practitioner who establishes her own practice.

At the joint meeting, there was considerable discussion concerning efforts to expand the role of the nurse in health care. IMS representatives were advised that the INA has been studying the Nurse Practice Act in terms of any legislative amendments that might be considered appropriate or necessary in light of recent trends.

The Liaison Committee is scheduled to meet March 20 to review a draft of proposed amendments to the Nurse Practice Act that will modify the definition of a nurse, as contained in the present statute, even though it is anticipated no effort will be made by the INA to seek legislative action during the current session of the Iowa General Assembly. The Society representatives will be prepared to offer appropriate comments and recommendations.

At the last session of the Iowa Legislature, a bill was introduced into the House of Representatives to "establish health service centers for the delivery of health care by public health nurses, and making an appropriation." The bill was not enacted, and the Committee will be alert to similar legislation which might be introduced during the present session.

Herman Smith, M.D., a member of the Committee, is serving on the Governor's Commission to Study Nursing in Iowa. The Commission is in the process of identifying and analyzing many of the perplexing problems confronting nursing—e.g., nursing practice, nursing education, and continuing education.

L. F. STAPLES, M.D., *Chairman*

## COMMITTEE ON DELIVERY OF HEALTH SERVICES

The Committee on Delivery of Health Services has been kept apprised of developments leading to the recent passage of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). The new law authorizes the establishment of a new federal program, which replaces current health planning activities of existing state and areawide Comprehensive Health Planning agencies, as well as the planning activities undertaken in the past by state Hill-Burton agencies, and some Regional Medical Program entities. Under the new law, each state is to designate "Health Service Areas" and establish "Health Systems Agencies" which will be nonprofit private corporations that will perform planning and development functions. By May 4, 1975, the Governor of each state is to submit to the Secretary of Health, Education and Welfare proposed boundaries for the health service area, or areas.

The Governor will appoint a special committee to make recommendations about the designation of a health service area and systems agency in Iowa, and the medical profession will be represented on this committee. In this connection, at the January meeting of the IMS Executive Council a motion was approved to support, in principle,

the designation of the State of Iowa as a statewide health service area, to be served by a single state health systems agency, with the understanding that IMS representatives can promote and modify this position as appropriate and necessary, as further study is given to this matter.

The Committee has also been kept apprised of steps which have been taken to establish a model regional primary health care center in southwest Iowa. Last November, Red Oak, Iowa, was selected as the site for the center, which is being funded with a grant from the Iowa Regional Medical Program to the University of Iowa College of Medicine. A group practice arrangement is being established, with two local physicians as the nucleus of the professional staff. Two additional family physicians will be added by July 1. It is planned that family practice residents and medical students will rotate through the center to receive community-based training.

The Committee chairman has served as one of the Society's representatives on the Advisory Committee/Family Nurse Practitioner Project, which is being sponsored by the IMS and Iowa Hospital Association, with funding from the Iowa Regional Medical Program. Details regarding the program are contained in the report of the Committee on Delegation of Authority.

The chairman, along with other IMS representatives, also attended a conference with the State Board of Medical Examiners last summer to review proposed rules and regulations governing the utilization of physician's assistants in Iowa. Discussion centered on approved training programs for PA's vs. equivalency training, duties and functions of the PA, and prescribing practices.

Last year, the Committee provided information on the preparation of a State Comprehensive Health Plan which OCHP is required to develop. A statement developed by the Committee and approved by the Executive Council, commenting on one of the original drafts of the proposed Plan, was included in last year's HANDBOOK report. In further reference to this Plan, the Society has had two physicians serving on a special OCHP committee responsible for preparing portions of the State Plan. The IMS representatives were involved primarily in drafting the section dealing with acute care services, including primary, secondary, and tertiary. They strongly supported the construction of a flexible plan in this regard, avoiding rigid specifications and formulas. The State Plan was to have been submitted to the OCHP Advisory Council in late February. The membership will be kept apprised of further developments and the status of the document.

The Society is being provided information and progress reports on an IRMP funded study currently being carried out by the Institute of Urban and Regional Research, Center for Locational Analysis, University of Iowa. The study is entitled "Planning Primary Health Services for Rural Iowa," and its objectives are to ascertain the decline of and accessibility to physicians and dentists in rural Iowa; predict future attrition in health manpower in rural areas; and choose optimum locations for the delivery of primary health care services in rural Iowa. It is understood that those conducting the study will identify the features of "ideal distribution," but will not attempt to devise policies to bring it about.

Another project which is being followed by the Society involves development of a "prioritized health manpower plan for the State of Iowa" to include the following licensed categories of health manpower: 1) medicine and osteopathy; 2) dentistry; 3) pharmacy; 4) podiatry; 5) optometry; 6) veterinary medicine, and 7) nursing. OCHP is undertaking the study, with a $65,000 grant from the U. S. Public Health Service.

The Committee is pleased that one of the Society's legislative priorities this year is support for an appropriation for the Family Practice Residency Program. The U. of I. College of Medicine has requested $2.9 million for continuation and expansion of the Program for the 1975-76 biennium, and the amount recommended by the Governor is $1,535,000.

The Committee will continue to keep apprised of developments in the broad area of "delivery of health services" to the people of Iowa, and stands ready to meet with appropriate state officials and agencies, and voluntary provider organizations to discuss various programs in this regard.

MAX OLSEN, M.D., *Chairman*

## COMMITTEE ON DRUG ABUSE

At its 1974 Annual Meeting, the House of Delegates charged the Committee on Drug Abuse with the responsibility for submitting a report to the House in April 1975 regarding the feasibility and propriety of conducting a data collection survey on the drug prescribing practices of physicians, with specific reference to (1) the cost of conducting such a study, (2) the mechanics to be used in implementing it, and (3) obtaining necessary assurance for maintaining control over the results of the study. This action was taken in response to an interest expressed by the Committee in assessing the imagined or real problems related to the misuse and abuse of licit drugs.

As a follow-up to a September meeting of the Committee, a conference involving representatives of the Committee and Jean Gagnon, Ph.D., Assistant Professor, University of Iowa College of Pharmacy, was arranged late in the fall to determine the availability of existing data relating to the drug prescribing practices of physicians. Dr. Gagnon reported on various studies that have already been made in this regard—e.g., the effect of quality and frequency of prescriptions upon price, the relationship between physician characteristics and scripting habits (i.e., age, location, specialty, etc.); he also advised that the College of Pharmacy has computer data on 30,000 prescriptions from which information and statistics can be obtained concerning frequency, duration, quantity, quality, refills, dosage, cost, and selling price. The prescriptions were obtained from physicians in private practice throughout Iowa, as well as through University Hospitals.

Dr. Gagnon agreed to provide the Committee with some raw data from a random sampling survey for its review in determining whether a more "sophisticated" study would be feasible and beneficial. The preliminary material has been compiled by Dr. Gagnon, and the Committee will meet sometime in March to peruse it and determine whether a recommendation should be made to the House that a more detailed and comprehensive study be undertaken.

If a more thorough study is deemed desirable, the Committee wishes to emphasize it would be implemented strictly as an information-gathering project to ascertain the prescribing practices of physicians for certain specified categories of drugs (i.e., psychotropic) in terms of quantity, dosage and refills; further, the results of the study would be analyzed and evaluated to determine which drugs might be subject to misuse, and whether or not it would be beneficial to develop an appropriate educational program for physicians, based on any problem areas that might be identified as a result of the study.

A final report regarding this project will be submitted in a supplemental report to the House of Delegates in April.

The attention of the membership is called to two arti-

cles published in the IMS JOURNAL during the past year; one on "Methaqualone" prepared by Kirk Strong, M.D., a member of the Drug Abuse Committee, and Dennis Kelling, Pharm.D., professor of clinical pharmacy at the U. of I. College Pharmacy; and one an interview with the chairman concerning the activities of the Drug Abuse Committee.

F. W. BENNETT, M.D., *Chairman*

## COMMITTEE ON EYE CARE

The Committee on Eye Care has not held a formal meeting since the 1974 House of Delegates. Several items of interest have been distributed to the Committee for information and comment, but no official actions have been necessary.

The Committee has noted that the Board of Regents has approved the purchase of 20 positions for Iowans at optometry schools across the country. This action was in response to a Legislative Interim Study Committee which has considered the question of the need for a college of optometry in Iowa either at the College of Osteopathic Medicine and Surgery in Des Moines or the University of Iowa in Iowa City. The Committee understands that the entire matter of the need for a college of optometry in Iowa is still under study.

A. H. DOWNING, M.D., *Chairman*

## COMMITTEE ON GROUP INSURANCE

This year the Committee on Group Insurance has reviewed the existing programs which are available and has added one additional coverage for the consideration of Society members.

The new Statewide Physicians Group Health Program offered through Blue Cross/Blue Shield has moved into its second year of existence. Participation in the program has increased steadily. There are 306 groups now enrolled representing 933 contracts and covering approximately 2,100 persons.

IMS members are reminded that the BC/BS coverage is available to physicians, their families and employees. Basic features include: BLUE CROSS—365-Day Comprehensive (80/20 Coinsurance $250 maximum), 365-Day Nervous and Mental, 365-Day Drug Addiction, TB & Alcoholism, Inpatient Diagnostic, and Physical Therapy Admissions; BLUE SHIELD—365-Day UCR, 365-Day Drug Addiction, TB & Alcoholism, Inpatient Diagnostic, and Ambulance—Air & Ground. In addition, there is a $250,000 major medical provision.

The monthly rates which became effective January 1, 1975 are $19.45 for the single coverage and $50.35 for the family coverage. If the program is accepted by an office or clinic all permanent full-time employees must participate except those who are included in group programs held by spouses.

It should be pointed out the older BC/BS coverage offered to IMS members continues to be available. This coverage was modified slightly last year when the new program was initiated.

Stepped-up efforts have been undertaken in 1974 by The Prouty Company to make Society members aware of the programs and services which are available under their auspices. A packet of printed materials has been assembled which contains folders on the several plans available to IMS members. These "expanded services" now include counseling on estate planning, professional corporations, HR-10 programs, etc. This counseling has taken the form of contact with individual physicians as well as presentations at meetings of county medical societies and specialty groups.

Improvements were made in the IMS Office Overhead Expense Plan in 1974. Benefits were increased to $1,500 per month and the plan was made "guaranteed renewable" at no additional charge to members. An open enrollment was held.

In 1974 an Improved Total Disability Rider was added to all new policies issued under the Accident and Sickness Disability Income Plan. Effective 12/1/74, all insured members were provided upgraded total disability benefits. The formal endorsement has not been added to all policies, it is hoped this can be accomplished by the renewal date of 6/1/75. This added benefit is provided with no increase in cost. Improvement in the severe loss ratio has been achieved since corrective action was taken in 1972. Additional time and further participation by younger physicians will help alleviate the loss problem. Efforts toward increased participation will be continued in 1975.

The Society's Life Insurance Plan will have a period of open enrollment in 1975. This program is underwritten by The Bankers Life.

Nationwide loss problems have developed in the Excess Major Medical Plan. The Northwestern National Insurance Company reports an underwriting loss of $1.9 million in the first nine months of 1974. This is in marked contrast to Iowa where the loss experience has been minimal and the participation by members has been good. An upward rate adjustment to cover this national loss has been deferred until August 1975. In the meantime, The Prouty Company is considering alternatives to avoid this increased cost, either through the Northwestern or another company.

The Prouty Company has been involved in discussions with Blue Cross/Blue Shield and the Committee on Group Insurance over the possibility of acting as sales administrators for the new BC/BS Health Benefit Plan. There appear to be many advantages in this arrangement. An agreement is being developed at this time.

Preliminary consideration has been given to offering IMS members a pre-paid dental program. This study will be continued in 1975 to determine the degree of member interest.

The Prouty Company has been involved preliminarily in the consideration of a group professional liability insurance program for Iowa physicians. Authority has been given by the Executive Council to permit the Society to undertake a feasibility study with the insurance brokerage firm of Rollins, Burdick Hunter. Supportive use may be made of The Prouty Company in this investigation.

In October 1974, the IMS Executive Council approved a recommendation of the Committee on Group Insurance that a Workmen's Compensation Savings Program be instituted for interested members. This program has been offered to Iowa physicians by the Dodson Insurance Group of Kansas City. It should be noted that medical associations in Minnesota, Arkansas, Pennsylvania and New Mexico have had favorable experience with this type of program over a brief period. Savings or dividends are provided to participants on the basis of claims experience. The prediction is that the savings will be between 30 and 40% of the premium. IMS members are encouraged to consider this program. Information is available on request from Society headquarters.

R. S. GERARD, M.D., *Chairman*

## COMMITTEE ON HEALTH CARE IN CORRECTIONAL INSTITUTIONS

The Committee on Health Care in Correctional Institutions submitted an extensive report to the 1974 IMS House of Delegates on its evaluation of the State's prin-

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cipal correctional facilities. This report, which was accepted totally by the House, was transmitted to Mr. Nolan Ellandson, Director, Division of Correctional Institutions, State Department of Social Services, and to the superintendents of the four state facilities. The report was also provided to the American Medical Association.

The 1974 House acted to continue the Committee by approving the following Resolved: That the Iowa Medical Society consider the continuation of this or a similar committee to assess and report on health care provisions in city and county jails in Iowa.

The Committee has met on one occasion to pursue this assignment. Subsequent to this meeting, a listing of the county and principal municipal jails was obtained, a survey questionnaire was developed, and the survey mailing was made. A good response has been received.

The manner in which these questionnaires are to be compiled and reported to the House is still under study. The information contained in the responses is broad in nature and may be difficult to amass in meaningful form. Further study is being given to the matter.

A. P. RANDOLPH, M.D., *Chairman*

## HISTORICAL COMMITTEE

No new projects were undertaken by the Historical Committee during the past year. The Committee continues to encourage county medical societies to prepare manuscripts dealing with the history of medical practice and medical society organization in their areas. Any documents of this nature can be submitted to the IMS for inclusion in its library. In addition, the Committee will be happy to reproduce limited quantities (25-50) of historical papers for use both by the author and the IMS.

O. N. GLESNE, M.D., *Chairman*

## COMMITTEE ON INDEPENDENT LABORATORIES

The Committee on Independent Laboratories has considered one or two matters during the past year. At the request of a member physician, consideration was given to the medical laboratory evaluation program which has been initiated by the American Society of Internal Medicine (ASIM). It should be recalled the IMS Executive Council approved January 24, 1974, a recommendation of the Committee on Independent Laboratories that Society endorsement be given the voluntary Proficiency Evaluation Program (PEP) offered by the College of American Pathologists.

The Committee was advised the ASIM is seeking approval and endorsement of its program among the states. It was noted that ASIM participated with the CAP until electing to sponsor its own program last year. It was noted further the ASIM program is tied in with the American Association of Bioanalysts.

After considering the ASIM program, the Committee elected to take no action at this time in terms of recommending IMS endorsement. It was acknowledged that physician interest in any laboratory evaluation program is limited.

The State Department of Health has provided the Society with current information on the qualifications which are required under Medicare for the clinical laboratory technologist employed in an independent laboratory. Several options are available and one must be pursued by the person who works in an independent laboratory. At the present time, these Medicare requirements do not apply to the technologists employed in a hospital laboratory.

G. R. CLARK, M.D., *Chairman*

## COMMITTEE ON INDUSTRIAL HEALTH

The Iowa Medical Society has been in contact with the Office of the Iowa Industrial Commissioner this past year. Concerns in several areas have been discussed, e.g., the intended meaning of disability, total or partial, in the Social Security and Workmen's Compensation programs; the interpretation of the word "release"—whether it means from treatment, to return to the same job, or a restricted job; the administrative mechanics of authorizing and granting Workmen's Compensation payments; and the need for referrals, consultations, evaluations, etc.

The American Medical Association has provided comment regarding amendments in the Occupational Safety and Health Act of 1970. Certain changes in the law have been recommended by the AMA in pursuit of the goal of preventing injuries and occupational diseases among American workers.

SIDNEY BRODY, M.D., *Chairman*

## MD-DO LIAISON COMMITTEE

The Committee has continued to stand ready to assist whenever and wherever problems may arise regarding MD-DO relationships. The relationships between MD's and DO's in Iowa have been such that very few problems ever reach the state level but are handled quite satisfactorily on a local basis.

The Committee is well aware that many osteopaths are active members and/or officers of county medical societies. In addition, twenty-four (24) osteopathic physicians and surgeons are active dues-paying members of the Iowa Medical Society.

J. M. RHODES, SR., M.D., *Chairman*

## MEDICAL ASSISTANTS ADVISORY COMMITTEE

The American Association of Medical Assistants, State of Iowa, Inc., is an active chapter of the national organization, and it carries on many beneficial educational programs for its members. The main objective of AAMA at the local, state, and national levels is to promote the education and professionalism of medical assistants. The AAMA represents approximately 16,000 individuals who work under the direct supervision of licensed physicians. These assistants serve as a direct link between the doctor and his patients, his colleagues, and suppliers of medical equipment and pharmaceutical products.

The Iowa Medical Society assists the state chapter in printing its quarterly membership newsletter, which reports on various programs and activities of the organization. Members of the Advisory Committee, as well as IMS staff, stand ready to provide assistance and counsel when requested.

Jeanne Green, who has been my medical assistant for 25 years, serves as a trustee of the AAMA.

The Annual Convention of AAMA/State of Iowa will be held in Davenport, Iowa on April 11, 12, and 13, and IMS representatives plan to be in attendance.

JAMES F. BISHOP, M.D., *Chairman*

## COMMITTEE ON MEDICINE AND RELIGION

The Committee on Medicine and Religion received with regret the announcement that, due to budget considerations, the AMA has eliminated its Department of Medicine and Religion. The IMS Committee and staff had maintained liaison with the AMA department on various matters involving contacts with Iowa physicians and clergymen.

Your Committee chairman has visited with U. of I. College of Medicine faculty members concerning educational programs that have been initiated there for medical students on matters relating to ethics, morals, and religion. The Committee is pleased that these subjects are being included in the curriculum.

Last year at the IMS Scientific Session in Iowa City, David Belgum, Ph.D., a professor in the College of Medicine and School of Religion at the University of Iowa, led a roundtable discussion on "Bio-Medical Ethics." It was an interesting session, and the Committee hopes that subjects in the broad area of medicine and religion will continue to be included in IMS scientific meetings.

The Committee is anxious to assist any county medical society in developing medicine and religion projects at the local level, and would be happy to participate in joint meetings involving physicians and clergymen.

O. E. SENFT, M.D., *Chairman*

## COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE

The Committee on National Emergency Medical Service, which has overlapping interests and membership with the Society's Community EMS Committee, did not consider any specific items during the past year. However, it will continue to serve on a standby basis, and will cooperate with departments of state government and any other agencies which are involved in civil defense programs or those concerned with natural or man-made disasters.

R. C. LARIMER, M.D., *Chairman*

## COMMITTEE ON ONCOLOGY

Three matters have been referred to the Committee on Oncology this year either for its information or informal opinion. These include:

1. A communication from the Iowa Division, American Cancer Society, which describes preliminary plans to acquire a mobile thermography unit for breast cancer detection. A feasibility study will precede acquisition of the unit to determine further (a) the medical aspects of this diagnostic program, (b) the degree of receptivity among physicians and adult females, and (c) the availability of follow-up services. The plan, as now conceived, calls for the Iowa Division to buy and maintain the "mobile thermography unit for the detection of breast cancer" in the State of Iowa for up to three years, at which time, another organization or institution would assume responsibility for operating costs, etc.

2. A request from the University of Iowa College of Medicine to support its efforts in pursuing a planning grant to develop a cancer control program for Iowa. This activity is being urged and funded by the National Cancer Institute and emphasizes community-based types of cancer control programming. The Society has provided a letter in support of this effort by the College of Medicine with the understanding that planning is to be emphasized in the first phase of any contract which is awarded. The Society is to be represented on an Iowa Cancer Council which is to be appointed to develop the proposed unified cancer control program. The Committee was represented by R. E. Weland, M.D., at a meeting last summer at which the program was described.

3. An effort by the Iowa State Department of Health to clarify with the National Cancer Institute a federal cervical cancer program planning proposal. In this consideration, State Health Commissioner Norman Pawlewski expressed reservations over the program's limited availability of funds to support treatment once a cervical cancer is detected. After evaluation, the Department of Health has determined it will not pursue participation in the federal program. This decision was reached in part because of the low and declining mortality rate from cervical cancer in Iowa.

G. R. CLARK, M.D., *Chairman*

## COMMITTEE ON ORGAN TRANSPLANTATION

In October, 1969, the Executive Council of the Iowa Medical Society approved in principle a program instituted by the University of Iowa College of Medicine to retrieve and preserve cadaver organs for transplantation. In the fall of 1972, the Iowa Medical Society's Legislative Committee endorsed a committee report recommending the definition of "brain death" for a place in the Code of Iowa. There were some legislative rumblings concerning this bill, but it ended up in limbo.

The need for such legislation has been identified by the Committee as high priority, and a substitute bill patterned after recent California legislation will be recommended. This bill *recognizes* rather than *defines* "brain death" as an alternative to a natural death. The Committee has considered asking the legislature to allow indication on the driver's license of the holder's desire to donate an organ for transplantation.

The University of Iowa Transplant Program is one of the largest in the country, and therefore its cadaver needs (80% of all transplants) are considerable. It is apparent from previous studies that there are adequate numbers of cadaver donors in the State; the reduced speed limit notwithstanding. Almost every physician has been contacted regarding cadaver needs for transplantation. Hospital administrators have also been alerted to the needs, and it is the intent of this Committee to see that hospitals are adequately compensated for their services. Physicians participating in organ recovery will also be compensated.

Professional education will be continued through the JOURNAL OF THE IOWA MEDICAL SOCIETY, and perhaps a forum at our annual meeting. The lack of adequate numbers of cadaver organs is acute. The backing of the Iowa Medical Society is essential to improve the rate of cadaver organ recovery.

R. L. LAWTON, M.D., *Chairman*

## COMMITTEE ON PARAMEDICAL SERVICE

Activities of the Iowa Medical Society in this area continue to be assigned to specific special committees. So, while the Committee on Paramedical Services has not met in 1974-75, considerable attention is being given nonetheless to matters involving paramedical workers. Following are several examples of this activity:

1. The newly formed Iowa Physician's Assistant Society has requested formal liaison with the Iowa Medical Society. This request has been approved and the Committee on Interprofessional Activities has been assigned to provide this liaison. The training of physician's assistants continues at the University of Iowa and the employment of PA's by Iowa physicians is increasing gradually.

2. A Family Nurse Practitioner (FNP) project is in process under the sponsorship of the Iowa Medical Society and the Iowa Hospital Association. The year-long project is involving six registered nurses in a study program which rotates between on-site indoctrination under a preceptor physician and formal instruction at the University of North Dakota. The six nurses will be prepared to work in a satellite clinic under an employing physician.

3. The first draft of a document entitled "Essential Ele-

ments for Institutional Physical Therapy Services" is being evaluated by a joint committee of the Iowa Medical Society, the Iowa Hospital Association and the Iowa Physical Therapy Association. This effort to clarify the in-hospital role of the physical therapist has been in process for approximately six months and is of significance.

The Society continues to be supportive of such organizations as the Iowa Chapter, American Association of Medical Assistants. Assistance is provided in various ways.

Those young people who request information about careers in the health field are provided printed materials on a routine basis.

J. T. BAKODY, M.D., *Chairman*

## PRECEPTORSHIP COMMITTEE

The Preceptorship Committee met in February with representatives of the University of Iowa College of Medicine to review the preceptorship program at the College of Medicine.

Medical students are required to complete a two-week preceptorship with a primary care physician within the third year in medical school. The response from students who have completed their required preceptorships has been generally very favorable; a similar reaction exists among 25 senior students who are participating in elective preceptorships. The "feedback" provided by the students regarding the effectiveness of their preceptorships is important and is carefully reviewed by faculty. Individual reports concerning a student's evaluation—both the positive and negative aspects—are sent to the preceptors.

The Committee also maintains its interest in the MECO Program (Medical Education and Community Orientation) initiated by the Iowa Chapter/Student American Medical Association, and endorsed by the IMS, Iowa Academy of Family Physicians, Iowa Hospital Association and College of Medicine. This education project was established five years ago to place freshman students in community hospitals during vacation periods to increase the scope of their education, and to enhance their interest in practicing in smaller communities. In 1974, 81 students served in 51 hospitals. Efforts are also being made to place freshman students not involved in the MECO project with primary care physicians for a one-week period, on an elective basis.

Both the use of evaluation forms by preceptees and the placement of freshman students in a primary care preceptorship have occurred as a direct result of recommendations from the Committee.

Information on the "Primary Care Preceptorship Program for Faculty," a new continuing education activity instituted at the College of Medicine, was provided to the Committee. Under the program, interested faculty members will spend three days with practicing physicians in their communities, and, in turn, the local physicians will spend time with their faculty "preceptees" at the College of Medicine. The program provides opportunity for faculty members to learn about problems confronting physicians in their local practices. Twelve faculty members will participate this year.

There is agreement by both the members of the Committee and the faculty representatives that the IMS Preceptorship Committee should continue to function as a liaison with the College of Medicine, with responsibility for offering constructive suggestions regarding implementation of the Preceptorship Program and related matters. The Committee (1) commends the Preceptorship Program as instituted by the College of Medicine; (2) commends the implementation of the "Primary Care Preceptorship Program for Faculty," and (3) recommends that it be expanded and promoted as an important and valuable learning experience for both faculty members and physicians in private practice.

L. D. CARAWAY, M.D., *Chairman*

## COMMITTEE ON QUACKERY

The Committee on Quackery, and staff, maintain close liaison with the AMA Department of Investigation on all matters relating to quackery, and also on efforts of chiropractors to expand their scope of services, both at the state and national levels.

Representatives of this Committee confer as appropriate with the IMS Committee on Legislation on proposals pertaining to chiropractic which are introduced in the Iowa General Assembly.

The Society is also keeping apprised on various developments related to the use of acupuncture, and a file of pertinent background information is being maintained.

C. H. Denser, Jr., M.D., Des Moines, continues to serve on the AMA Committee on Quackery.

W. R. WHITMORE, M.D., *Chairman*

## COMMITTEE ON RURAL HEALTH

Your Committee chairman attended the national AMA Conference on Rural Health last April, at which Robert Rakel, M.D., Chairman of the Department of Family Practice at the University of Iowa College of Medicine, was a guest speaker. The chairman will also attend the 1975 National Rural Health Conference scheduled late in March, where attention will be focused on family practice programs; extending the role of the nurse; and the regional approach for rural health services.

Although the Rural Health Committee has remained inactive with respect to implementing specific projects, it should be noted that the chairman also serves on the Delivery of Health Services Committee, which has interests similar to those of the Rural Health Committee in assuring the availability and accessibility of health care in rural areas.

The Committee will watch with interest the development of the model regional primary health care center that is being established in Red Oak, Iowa, and which is being funded with a grant from the Iowa Regional Medical Program to the University of Iowa College of Medicine. Additional information regarding this program is contained in the report of the Committee on Delivery of Health Services.

MAX OLSEN, M.D., *Chairman*

## COMMITTEE ON SPORTS MEDICINE

Approximately 200 coaches, trainers, physicians and other interested persons attended the 1974 Conference on Medical Aspects of sports sponsored by the Iowa Medical Society, the Iowa High School Athletic Association and the Iowa Chapter, American Academy of Pediatrics. The Conference was April 4 at the Des Moines YMCA.

Keynote speaker for the successful meeting was Fred L. Allman, Jr., M.D., Director, Sports Medicine Clinic, Atlanta, Georgia. The program topics included physical injuries (neck, spine, extremities, blisters, abrasions, etc.); conditioning; weight matters; summer fitness programs; and attitudes, values and conduct in athletics. Taping demonstrations were presented by trainers from Iowa State University, University of Iowa and Drake University.

This is the second statewide conference of this type arranged by the Committee on Sports Medicine in the past four years.

The Committee has considered an inquiry from the Iowa Football Coaches Association on the merits of wearing helmets during the initial four days of non-contact practice. The IFCA has suggested a gradual introduction of full gear may enhance the safety and conditioning of prep football players.

An informal poll of the Committee found a majority in favor of a modification in existing requirements to permit use of the football helmet in the first four days. These findings have been transmitted to the IFCA. The question will be discussed more thoroughly by the Committee.

The Committee has maintained its interest in weight determination as it applies to wrestling. Several articles on the subject have been provided to members of the Committee.

R. W. ANDERSON, M.D., *Chairman*

## COMMITTEE ON VOLUNTARY HEALTH AGENCIES

The Committee on Voluntary Health Agencies continues to remain on stand-by status. Just the same it is possible to report that ongoing positive liaison is carried on between the Society and various of the voluntary health agencies.

A number of Iowa physicians serve various voluntary groups in leadership capacities both at the local and state levels. It is important for the State's medical practitioners to allow some of their time and expertise to assist worthy volunteer organizations in the health field.

Recognition of the volunteer service of Iowa physicians has come in various ways. For example, the summer camp provided for diabetic youth at the Des Moines YMCA Camp is officially designated Camp Hertko Hollow in honor of E. J. Hertko, M.D., Des Moines, whose assistance to the Iowa Diabetes Association has been extensive.

To further illustrate the manner in which the Society cooperates with the voluntary bodies, it is appropriate to mention (1) that representatives of the Kidney Foundation of Iowa have met this year with the IMS Committee on Organ Transplantation; (2) the IMS has been recently advised by the Iowa Division, American Cancer Society, of a new proposal it is developing in the area of breast cancer screening; and (3) the IMS has participated with the Iowa Heart Association, the State Department of Health and others in a consideration of hypertension screening.

The AMA Directory of National Voluntary Health Organizations is kept on file by the Committee and is referred to as requests for information are received by the Society.

C. E. SCHROCK, M.D., *Chairman*

## WOMAN'S AUXILIARY ADVISORY COMMITTEE

The Woman's Auxiliary to the Iowa Medical Society is not a group of women gathered for an afternoon tea party. It is an organized group of physicians' wives carrying forward a vital program in behalf of the medical profession. The Auxilians support their physician husbands in professional, community and family endeavors in excellent fashion.

The WA-IMS continues to receive recognition on the national level. Mrs. Max E. Olsen is the North Central Regional Vice-President, and Mrs. Howard Ellis is chairman of Program Subcommittee on Research Project.

There are six national program extension committees selected for 1974-1975.

1. AMA-ERF raises funds in various ways, through projects, the solicitation of contributions and memorials, etc. The money helps increase the amount allotted The U. of I. College of Medicine, and it adds to the loan guarantee fund which supports medical students. The Committee is striving to meet a $15 per person goal.

2. The International Health Committee has been active in assisting Yucatan, Iowa's sister state in Central America. Much needed health care equipment and supplies have been collected for Yucatan. County auxiliaries have collected medical surgical supplies for use in Yucatan hospitals. Pharmaceuticals, medical equipment, johnny coats, bandages, etc., are delivered to a central point for transportation to Yucatan through the Iowa Partners of the Alliance.

3. The purpose of the Legislative Committee is to raise the level of political and legislative awareness. The Auxiliary recently hosted wives of Iowa's lawmakers at a Legislative Brunch and a health related program on child abuse by Dr. Gerald Solomons, Director of the Child Development Clinic at The U. of I. College of Medicine. The attendance was excellent, proving it to be a popular affair where excellent contacts are made and maintained. Three members of the Auxiliary are now on the IMPAC Board. Honor has come to the Auxiliary through the service of Mrs. Mary Louise Smith as national chairman of the Republican Party. She is the first woman to be appointed to this position.

The next three committees are new this year and are related to both health education and service.

4. The Health Education Committee was given recognition and impetus on a priority basis by National Auxiliary this year. In communicating with other states, we found many have initiated long-range plans for implementing comprehensive health education programs to elevate the quality of life for our children. As a start, we have been encouraging our members to accept positions on school boards, to learn of local practices in health education and to encourage the support and furtherance of state laws for health educators and curriculum standards.

5. The Committee on Family Health is a combination of three areas—self-discipline, family relations and detection: (a) self-discipline includes: nutrition and weight control, fitness, exercise, living productively for longevity, use and misuse of drugs; (b) family relations embraces parenting, broken homes, sexuality, and human abuse; and (c) detection includes testing and screening for sight, hearing, learning disabilities, diabetes, hypertension and driver limitation.

6. The Committee on Community Health includes prevention and care: (a) prevention: immunization (due to the trend of declining immunization levels among preschool children, the Auxiliary was especially active in this project) venereal disease, emergency medical identification, GEMS, block mother safety, blood donor, environment, and (b) care: friendly visiting, telephone reassurance, project re-entry, escort services, homemaker-home health aide services, court and home shelters, worry-in clinics, crisis lines for teens, day care, tel-med and talking books.

Another important WA-IMS project is the Health Education Loan Fund (HELF). HELF assists deserving young people in their pursuit of education. The Committee maintains contact with schools of nursing and area colleges to promote the loan fund. The fund now amounts to approximately $31,000. Two thousand dollars is the maximum amount of each loan, and we have funds avail-

able for eight new loans in the fall of 1975. One hundred and two nursing or paramedical students have received help from the fund. As of now there are five students in school using the loan fund and 11 graduates repaying loans.

The officers of the IMS are well aware of the valuable help provided by the WA-IMS. The Society frequently turns to the Auxiliary when a difficult problem needs attention.

Our hats are off to the members of the Woman's Auxiliary.

V. L. SCHLASER, M.D., *Chairman*

(This concludes the material published in the HANDBOOK FOR THE HOUSE OF DELEGATES.)

# Supplemental Reports

Presented by J. F. Bishop, M.D.,
Chairman, Board of Trustees

## BOARD OF TRUSTEES

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business)

As has been its custom, the Board of Trustees has developed this Supplemental Report to spotlight issues of vital concern to the medical profession, and to provide an up-to-date summary of activities that are of interest to the membership. Details regarding the projects of the Society's 20 Standing Committees and 28 Special Committees are contained in the House of Delegates HANDBOOK.

### PROFESSIONAL LIABILITY

It has been many years since individual physicians—and the medical profession as a whole—have been confronted with a problem as critical as the current professional liability insurance crisis. The Medico-Legal Committee, under the chairmanship of Doctor Clarence Denser, deserves special kudos for the tremendous amount of time and effort it has spent in attempting to work out reasonable solutions and to assure the availability of appropriate and adequate insurance coverage for physicians practicing in Iowa.

Professional liability is an issue of such magnitude that the Board of Trustees has created a special ad hoc committee to coordinate the activities of the Medico-Legal Committee, the Committee on Legislation, and the Board as they attempt to resolve our current and long-range problems. Doctor Denser, Doctor A. J. Havlik, Trustee, and Doctor Don Young, Legislative Committee Chairman, are serving on the coordinating committee.

Maximum effort has been and will continue to be made to keep the membership informed on the fast-moving developments in this crucial area of activity.

### HEALTH PLANNING AND DEVELOPMENT ACTIVITIES

Early in the year, the U. S. Congress enacted health planning and development legislation that has a potential for effecting vast changes in the manner in which health care services are organized and delivered in this country.

The new law authorizes the governors of each state to designate a health service area—or areas—for planning and health resources development. This is to be accomplished by May 3. A health systems agency will be created within each health service area to develop goals for the area, prepare annual implementation plans, assist in implementing the plan, review and approve—or disapprove—applications for federal funds for health programs, and assist a state health planning and development agency. The state agency activities will include developing statewide health plans, reviewing all capital expenditures of health facilities, determining the need for any new institutional health services, and reviewing the appropriateness of existing institutional services. Area and state agencies will also make recommendations on projects for modernizing, constructing, or converting medical facilities. The law provides for an expenditure of one billion dollars over the next three years for health planning and supervision of construction.

At its meeting in January, the Executive Council of the IMS approved, in principle, the designation of the State of Iowa as a statewide health service area, to be served by a single state health systems agency. This action has been reported to a special Task Force appointed by the Governor to make recommendations about area designations and related matters. Doctor John Tyrrell, of Manchester, was appointed by the Governor to serve as chairman of the Task Force.

The Society has provided background information regarding the new law, the position of the IMS, alternative proposals supported by other groups, and recommendations of the Task Force, to all county medical society presidents and secretaries, with a statement urging them to submit any individual or local county medical society views or comments to the Governor or the Task Force.

### CONTINUING MEDICAL EDUCATION

Continuing medical education has always been a priority concern of the Iowa Medical Society. We are proud of the quality of the scientific journal which is published each month, as well as the excellence of our annual scientific sessions.

Early this month—April 3-8, to be exact—I, along with approximately 125 other physicians and their spouses—took advantage of the opportunity to participate in the 1975 IMS Scientific Session that was held in Freeport, Grand Bahama. As anyone who was there will tell you, we had three full mornings—8:00 a.m. until 12:30 p.m.—of superb scientific presentations and discussions, and 100% attendance at the sessions. Of course, we also had time to enjoy the sunny climate and recreational facilities of the island. Doctor Wicks and the members of the Program Committee were commended by the registrants for arranging a very outstanding session.

Due to circumstances over which we had no control, it became necessary to change plans "mid-stream," so to speak. Originally, we were scheduled to hold the meeting on the island of St. Martin, but because of problems related to the energy crisis, we had to cancel out, and then were not able to confirm arrangements for the meeting in Freeport until December.

Plans for the 1976 Scientific Session are already underway. The meeting will be held in Iowa City next spring, and Doctor Schlaser has contacted physicians to serve on the Program Committee. The membership will be kept informed regarding specific dates and other details.

The Society has maintained close contact with the Board of Medical Examiners as consideration has been given by the Iowa Legislature to the establishment of continuing education requirements for re-registration of

licenses issued by all of the state's professional and occupational licensing boards. We support a recommendation of the Legislature's Interim Study Committee that, since each board is best equipped to determine what, if any, continuing education requirements are appropriate, each board should be granted statutory flexibility to make this initial determination.

In further reference to CME activity, this year's House of Delegates is being asked to authorize the IMS, through its Committee on Medical Education and Hospitals, to seek approval from the AMA as the official body in Iowa to accredit certain continuing medical education programs in Iowa. If this authority is granted, and the Society is approved by the AMA as an accrediting body, the IMS will assume an important responsibility in evaluating the educational resources of appropriate institutions and organizations in the state, with the long-range goal of improving the quality of continuing medical education for the practicing physician in the setting of his own hospital or local medical community.

## RELATIONS WITH ALLIED HEALTH PROFESSIONS

The IMS has always maintained close relationships with the official organizations of our allied health groups. We have not always agreed on every issue that affects us, but, in the main, we operate in an atmosphere of mutual support and cooperation.

For the past three years, the Iowa Health Council has arranged special educational programs for representatives of its member organizations, which, in addition to the IMS, include the dentists, pharmacists, nurses, osteopaths, nursing home operators, podiatrists, hospital administrators, and veterinarians. Subjects such as PSRO, implementation of new health planning legislation, quackery, and others have been discussed.

Two years ago, the Society established a formal MD/RN Liaison Committee, which provides an opportunity for our two professions to get together on a formal and somewhat regular basis. Special attention has been given in recent months to the expanding role of the nurse in patient care. At a joint meeting that was held late in March, IMS representatives were requested by the Iowa Nurses' Association to review and comment on a first draft of a proposed amendment to the Nurse Practice Act, which will modify the definition of the nurse as contained in the present statute. Several constructive suggestions were made to the nurses regarding their proposal, and another meeting will be held in the future to give further consideration to it. According to the INA, it does not intend to seek legislative action during this session of the legislature.

Over the years, the Interprofessional Activities Committee has also attempted to meet on a regular basis with representatives of the Iowa Pharmaceutical Association, and this effort has proved to be mutually beneficial. A project currently under consideration is the updating, reprinting, and redistribution of the Physician/Pharmacist Code of Understanding. This document was developed and approved by the IMS and IPhA in 1959, and amended in 1963. The committee feels there is a need to revitalize the Code, and to focus attention on the several provisions contained in it, which are intended as guides for both physicians and pharmacists.

The Board of Trustees, in consultation with the President, has appointed a special liaison committee composed of representatives from the Iowa Hospital Association, the Iowa Physical Therapy Association, and the Iowa Medical Society. The committee has met on two occasions to consider several matters regarding relationships between physicians and physical therapists, physical therapists and hospitals, and physical therapists and patients.

The catalyst for the meetings resulted from an Assistant Attorney General's opinion relating to the legality of Iowa hospitals employing physical therapists. The Iowa Medical Society is particularly concerned about the possible impact of the ruling on relationships with nurses and other groups licensed under Title 8 of the Code, "Practice of Certain Professions Affecting the Public Health."

The meetings have been most fruitful and a great deal of progress has been made. Additional meetings are planned, and final recommendations will be submitted to the Executive Council.

## IMS REGIONAL LEADERSHIP CONFERENCES

Officers and staff recognize the importance of keeping the membership informed on the various problems confronting us, and the efforts that are being made to solve them. We attempt to do this via the written word—special bulletins, the JOURNAL, and other communications—and also through personal contacts.

During the month of March, the Society arranged a series of five regional conferences, and these were held in Atlantic, Spencer, Amana, Waterloo, and Des Moines. Presentations were made on the subjects of PSRO and the Iowa Foundation for Medical Care, professional liability, the Society's legislative program, the AMA, and hospital/medical staff relations.

The final total attendance figure was disappointing—only 175 physicians and their spouses were present—especially since we arranged to repeat the program in five different parts of the state in order to reduce driving distance for a majority of physicians, and enhance participation by the membership. Judging from the comments and questions received from those who were able to attend these conferences, they served a valuable purpose.

## HOSPITAL-MEDICAL STAFF RELATIONS

As mentioned, one of the presentations at the area meetings concerned hospital/medical staff relations, with general references to the physician's inter-relationship with other health institutions, agencies and programs.

In light of the ever-changing health care delivery environment, the IMS Board of Trustees obtained from legal counsel a 37-page discussion document entitled "Guidelines for Relations Between Physicians and Hospitals—1975," and this material was summarized at the area meeting. Our next step is to cull from this legal brief—and from other resource material—items of the most salient interest to Iowa physicians, and then develop a set of principles or guidelines for them to follow in their formal, semi-formal, and informal relationships and affiliations. This material will be submitted to the Executive Council prior to any final printing and distribution to the membership.

## FINANCES

The $50 per member dues increase in 1974, coupled with fiscal responsibility and restraint, has enabled the Society to achieve a solid financial status. The Board has been guided by the actions of the House of Delegates, and specifically by the recommendations submitted by the special 1973 Interim Study Committee/IMS Finances.

The Board is pleased to report that no deficit financing has been necessary. Further, the 1975 Budget adopted by

the Board contemplates that actual depreciation funds will be available to set aside for future needs.

While a much improved society financial picture now exists, the Board nonetheless is concerned that the number of dues-paying members decreased by approximately 25 in 1974. The trend of recent years has brought the Society to a position where in 1974 the percentage of Iowa physicians who have IMS membership dropped below 90% of those eligible. In addition, the membership department reports that at the end of the first quarter of 1975 there are over 100 physicians who were members in 1974 who have not yet joined in 1975. Add to this number (100) those who were eligible nonmembers as of the end of 1974, and you find there are approximately 400 of our colleagues not supporting the Iowa Medical Society. The Board would like to request the assistance of all Delegates in explaining to their colleagues the importance of a strong, unified medical profession, especially in these most important and crucial times. Included in the Delegate packet is a listing of the physicians who, according to IMS membership records, have not joined in 1975. The Board fully understands that IMS membership is an individual, voluntary matter for each doctor to decide. We strongly support this concept. However, the Board believes equally as strongly that the performance of the Iowa Medical Society warrants and justifies the support of all physicians. Each Delegate is encouraged to review the list of eligible nonmembers and, when appropriate, find an opportunity to discuss the importance of IMS membership with his colleagues.

During the past year, the Board considered recent amendments to the Articles of Incorporation and By-Laws which make it possible to assess less than full dues against members over 70 years of age, if recommended by the Board and approved by the House of Delegates. Based on its study, the Board has determined that around seventy-five IMS members over 70 years of age are still in active practice. Doctors over 70 years of age who are not in active practice might well be eligible for another membership category (associate or life) which does not require the payment of dues. In view of its findings, the Board does not believe any change is indicated.

Based on the 1975 Budget and an evaluation of needs for 1976, the Board recommends that IMS dues for 1976 be established at $200 per member.

## IOWA FOUNDATION FOR MEDICAL CARE

One of the most important actions of the House in recent years was providing the stimulus and direction for the creation of the Iowa Foundation for Medical Care. It is now my pleasure to introduce to you the President of the Foundation, Doctor Kenneth E. Lister of Ottumwa, who will bring us up to date on PSRO developments, and other activities of the organization.

## REPORT TO IMS HOUSE OF DELEGATES IOWA FOUNDATION FOR MEDICAL CARE

K. E. Lister, M.D., President

On behalf of my colleagues on the Foundation Board, I would like to convey warmest regards to members of the House. It is my pleasure to present this fourth annual progress report of the Foundation.

This report will highlight major areas of Foundation activity this past year. These areas involve development of a workable plan for Professional Standards Review Organization implementation, peer review of professional fees, and communications.

### PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The Foundation devoted much attention during the last year to developing a formal plan for implementing PSRO activities in Iowa—an effort encouraged by the House at its last meeting. The Foundation applied for and was awarded a six-month planning contract from the Department of HEW. This contract provided the necessary funding to establish the Foundation's formal plan for administering PSRO duties. A cadre of fine physicians was appointed to various subcommittees of the Foundation to develop the various aspects of the plan.

A draft copy of the plan was submitted to HEW in November of last year. A critique letter was received in December. As a result, necessary changes were incorporated into the plan, and the final draft was submitted in late February of this year.

We expect HEW to publish a notification of its intent to contract with the Foundation shortly. This notification will appear in major newspapers around the state. Those physicians who feel the Foundation *does not* represent them as the PSRO are asked by the notification to express this opinion to the Secretary of HEW. If more than 10% of the M.D.-D.O. population respond in this manner to the Secretary, it will then be necessary that HEW conduct a poll of all physicians to ascertain whether the Foundation is representative. If more than 51% of the physicians *responding* to the poll indicate the Foundation does not represent them, the Secretary is then prevented from entering into a contract with the Foundation. After January 1, 1976, the Secretary is not bound to contract with a physicians' organization. The law provides that he may then contract with any other organization which shows capability for performing PSRO functions. The necessity of a poll would delay Foundation designation as the PSRO for at least three months and defer physician control of medical review. It should be understood by physicians that the notification and polling procedure is not a method to gain repeal of the PSRO Law; rather, it is a method for determining which organization best represents physicians in Iowa as the PSRO.

It has been the Foundation's role this past year to show leadership in capturing PSRO designation so that it is properly controlled by the profession. The Foundation's plan for PSRO administration represents the best workable approach which meets program requirements and protects individual physicians from unnecessary intervention.

Following is a summary of the Foundation's PSRO plan. A brief description of each section is provided:

1. **Program Status**—This section describes established IFMC programs and projects and sets forth the present peer review structure of the Foundation. It is proposed this existing structure will be used as the primary review mechanism.

2. **Organization**—The 20-physician member Board of Directors of the Foundation is presented as the principal governing body of the PSRO. As reported to the House last year, the Foundation must restructure its Board so that all members are elected. The present structure provides for eight positions on the Board to be held by the IMS Trustees.

3. **Membership**—For PSRO purposes the Foundation is required to have at least 25% of the actively practicing physicians as Foundation/PSRO members. The IFMC is pleased to report that over 70% of the Iowa physicians are so classified. However, it has been necessary for the Foundation to re-enroll physicians to comply with PSRO requirements.

4. **Assessment of PSRO Area**—Certain statistical information of the Iowa PSRO area was presented, i.e., data on numbers and location of physicians, numbers and types of hospitals, etc. Information for this section was drawn from a survey of hospitals conducted in late 1974.

5. **Formal Plan**—Nine specific plan areas were presented in this section. They are as follows:

- Plan for administrative coordination with Medicare/Medicaid, Maternal and Child Health and Crippled Children programs—The state agencies responsible for these programs must have a liaison relationship with the Foundation when it becomes designated as the PSRO. The nature of this relationship is being developed through memorandums of understanding. Since the Foundation will have fiscal authority on payment of claims, a methodology for coordinating review efforts with the fiscal agent's payment functions is specified in the memorandas.
- Plan for concurrent review—A model program for conducting in-hospital concurrent medical review was created by the Foundation. This provides a methodology for conducting admission review and continued stay review which can be adapted by hospitals to meet their particular needs.
- Plan for medical care evaluation studies—A model program for conducting in-hospital medical care evaluation studies was created by the Foundation. As with concurrent review, this program contains a methodology adaptable to hospital needs. Copies of the concurrent review and medical care evaluation programs can be obtained by contacting the Foundation office.
- Plan for profile analysis—Data generated through concurrent review and medical care evaluation will assist the Foundation in determining the effectiveness of the review process and will aid in identifying strong and weak aspects of the review system.
- Plan for delegation of hospital review—Somewhat unique to Iowa is the Foundation's commitment to delegate the review responsibility to individual hospital medical staffs. Other states have elected to take a more centralized approach to medical review. It is the belief of the Foundation that the most accurate, effective, and acceptable form of peer review is that which takes place locally. Included in the Iowa delegation plan are certain criteria which a hospital review program must meet to qualify for delegation responsibilities. This delegation criteria will be included in a forthcoming letter to hospital chiefs of staff and administrators.
- Plan for establishment of criteria, standards, and norms—The Foundation's Standards Review Committee is responsible for updating the *Iowa Standards of Health Care*. The Foundation is fortunate to have these standards in existence. They were developed initially by the Iowa Medical Society's Subcommittee on Medical Review in cooperation with state specialty groups.
- Plan for linking review findings with programs of continuing medical education—It is generally assumed that much of the purpose of PSROs is to have the greatest impact in cost containment. However, it is the prerogative of the law and the desire of the Foundation to maximize PSRO potential by translating patient care problems and solutions into educational programs. The Foundation expects to encourage and support continuing medical education activities through existing education mechanisms.
- Plan for involving nonphysician practitioners—The Foundation has established lines of communications with several nonphysician practitioner groups. In addition, the Foundation Board has appointed an Advisory Committee comprised of representatives from the insurance industry (both commercial and private), the Iowa Hospital Association, the Iowa Podiatry Society, the Iowa Optometric Association, the Iowa Pharmaceutical Association, the Iowa Nurses' Association, and the Office of Comprehensive Health Planning.
- Plan for data—Two forms of data collection have been identified by the Foundation as being critical to PSRO operation. First, hospital medical staffs should have available to them data to support concurrent review and medical care evaluation programs. Information must be available to the medical staff for use in evaluating care and modifying criteria and norms. Secondly, the Foundation will need specific data to assess the overall functions of the hospital medical review programs. The Foundation is seeking an approach which will assure both operational feasibility and confidentiality.

Most of the effort in developing the plan came from practicing physicians who share your concern about interference with professional decisions. Part of the proposed plan comes from programs which already exist in these hospitals: St. Luke's and Mercy in Cedar Rapids; Mercy and St. Luke's in Davenport; Mercy Hospital in Des Moines; Jennie Edmundson Hospital in Council Bluffs; Pella Community Hospital; and the Fort Dodge hospitals. These are good programs developed locally to meet the hospital needs. It is the desire of the Foundation not to disturb these programs where they are effective.

## FEE REVIEW

The Foundation was very active in peer review disputed cases involving professional fees during 1974. Last year, the Foundation received 1,106 cases and made recommendations on 1,059 cases. The Foundation continues to receive the support of most of the commercial carriers in the state and Blue Shield. Decisions rendered by the committee are supported by the insurance companies unless it is felt necessary to appeal the decision to the Foundation Board.

The Foundation continues to serve as a valuable mechanism for resolving fee disputes with insurance companies. Physicians are encouraged to request peer review on disputed decisions, either by requesting the case be sent to peer review by the insurance company or by contacting the Foundation office direct.

## COMMUNICATIONS

As a result of a recommendation to the Foundation by last year's House of Delegates, increased efforts to communicate Foundation objectives and activities were initiated. These efforts began early last fall with meetings with county medical societies. In total, 30 meetings were held with local societies representing 80% of the physician population in the state. These meetings were successful both in spreading the Foundation word and receiving valuable feedback from concerned members.

Last fall, the Foundation co-sponsored with the Iowa Hospital Association informational seminars held regionally around the state. Chiefs of staff and utilization review chairmen were invited to attend these meetings. Information regarding program status and model medical review programs were presented.

The Foundation began issuing a monthly newsletter in January. These publications have provided current information on Foundation status, committee activities, and a brief philosophical remark by Board members. You are encouraged to read these newsletters and give us your thoughts on future content.

In addition to the above, Foundation Board members and staff have participated on numerous panels and made presentations to various groups on the organization's purpose and activities. Hopefully, our efforts have established a greater understanding of the Foundation among the physicians' population.

## SUMMARY

The investment the Iowa Medical Society made in creating the Iowa Foundation for Medical Care three years ago is now beginning to show dividends. It was the Society's intent to create a professional organization which could prevent intervention by third parties, government, and consumer advocates. The Foundation has fulfilled this role through a viable system of peer review and a physician-controlled method for implementing PSRO.

*(Resumption of the report by Dr. Bishop.)*

## BLUE SHIELD

An excellent relationship exists between the Iowa Medical Society and Blue Shield of Iowa, and this is due in large part to the close communication that is maintained between the officers and staffs of the organizations. It is now my privilege to introduce Doctor Radcliffe.

# BLUE SHIELD OF IOWA REPORT TO IMS HOUSE OF DELEGATES

C. E. Radcliffe, M.D.,
Chairman, Blue Shield of Iowa Board of Directors

Along with the other members on the Blue Shield of Iowa Board of Directors, I would like to thank the Iowa Medical Society for its support during the past year. This support has been of significant value in helping us achieve the goals outlined in this report. We are aware of and thankful for the input and direction which this House of Delegates provides toward the development of more effective mechanisms for health care delivery.

The Blue Shield of Iowa membership roll included 1,199,393 regular business participants at the end of 1974. This figure represents a substantial growth of 69,380 members over the previous year. The physicians who founded the plan many years ago deserve our praise for their far-sightedness in structuring a Blue Shield of Iowa which has been able to remain responsive to the ever-changing needs of the public we serve.

As you know, it is our ultimate goal to return the most dollars possible to subscribers and physicians in the form of benefits. We were the 20th largest Blue Shield plan in the nation in 1974. We achieved this ranking by paying over $100 million in medical and surgical benefits through our regular lines of coverage and through our public service role as a fiscal intermediary for the various governmental health care programs.

Members covered by regular Blue Shield contracts received $65 million in benefits during 1974 for physicians' services. This amount represents an increase of $13 million in medical and surgical payments over 1973.

In addition to payments made for claims incurred under our regular lines of business, another $25.9 million was disbursed for physicians' services provided under the Part B Medicare program, $869,000 under the CHAMPUS program for military personnel, and $8.3 million under the Medicaid program. These 1974 payments total over $100 million.

We attribute our membership and benefit growth to the continuous involvement and support of the Iowa Medical Society, to the direction provided by the practicing physicians and lay representatives on the Blue Shield Board of Directors, and to our strong working relationship with Iowa physicians. In addition, we recognize the outstanding leadership and dedication of Bill Recknor, Executive Director of Blue Shield of Iowa, and the entire administrative staff, indeed, accomplishments such as those marked by Blue Shield of Iowa in the past years are attained only through cooperative efforts to reach established and clearly defined goals.

It is our primary objective to provide the best in health care coverage to our members. To this end, the Blue Shield Marketing Department is engaged in an ongoing effort to increase the number of participants covered by UCR contracts; such action has been encouraged by this House of Delegates, this effort has produced 930,436 participants with UCR benefits, or 90% of the Blue Shield members under age 65. In 1974, the number of participants with UCR coverage increased by 203,820 and the UCR penetration of contracts held by Blue Shield members under age 65 increased from 76 to 90. We are, indeed, pleased with this record of growth in UCR contracts and with the improved benefit coverage it provides for thousands of Iowans.

Our Major Medical Program, which offers a quarter of a million dollars in lifetime benefits, covered 662,062 Iowans at the end of 1974. This represents a sound growth of 243,125 participants over 1973. Approximately $5 million in Major Medical benefits were paid last year, amounting to an increase of $1 million over 1973. We firmly believe the total benefit package provided by our comprehensive basic coverage and Major Medical is one of the best programs marketed today. Much of the credit for the implementation and effectiveness of this two-fold program belongs to Iowa's physicians.

In accordance with requests from the Iowa Medical Society, (1) we have increased outpatient benefits within a reasonable price structure, and (2) we have studied alternate delivery systems in an attempt to experiment with other methods of delivery, while at all times maintaining the quality of the care provided, for the record, Blue Shield of Iowa paid $4.8 million in out-patient benefits during 1974.

In the area of alternate delivery systems, Blue Cross and Blue Shield of Iowa are working to finalize plans with Rural Health Services, Inc., a prepaid group practice located in Bloomfield, to provide marketing and administrative services.

The legal counsel for R.H.S. is developing a presentation for the members of the ADS Committee of the Iowa Medical Society for the purpose of gaining their support and approval for the program. Through the input of this committee we hope to determine and gain final clarification on the territory to be served, which is essentially the only decision left to be made with respect to internal planning and development.

The benefit package offered by Rural Health Services is extensive. It includes all inpatient and outpatient care, office and home visits, prescription drugs with a $1 deductible, and ambulance service. The only exclusions are benefits for dental, eye and cosmetic care.

According to the plan, physicians will be paid on a capitation basis each month, which precludes any claims processing in-house at Blue Shield of Iowa. Hospitals are paid on a per diem basis according to the estimated number of days per month required to provide care to the projected population. Claims processing would be neces-

sary only in those cases involving referral services both in-area and out-of-area, and for emergency care.

Blue Shield of Iowa is currently involved in several other ADS projects. One is a pilot program being developed by Mercy Hospital in Des Moines. This is a patient assessment and diagnostic evaluation program, which involves a diagnostic workup on an outpatient basis. It has been designated as PADE and is scheduled for May 1 implementation at Mercy.

The PADE concept permits payment for outpatient diagnostic x-ray and laboratory services in addition to the professional services for cases that can be treated on an outpatient basis. The obvious intent is to reduce the number of hospital admissions. In order to qualify for the program, patients must have a symptom or illness that requires evaluation and diagnosis or a proper course of therapy. There must be a condition to require a diagnostic workup prior to a hospitalization. The program does include a peer review mechanism to assure that all patients are provided with services of high quality and to insure appropriate utilization.

In addition to ads and outpatient benefit expansion, Blue Shield of Iowa with the input of the Iowa Medical Society, is working to improve other mechanisms for the more effective delivery of health care.

In last year's report we introduced a new uniform Nomenclature and Coding System, developed in conjunction with the IMS and AMA. The CPT Coding System was developed to expand the definitive capabilities of coding and to more accurately designate the multitude of services performed by the medical profession. In addition, because claims can now be pre-coded in the physician's office with the five-digit code, plus modifier and the narrative description, coding errors can be reduced.

The conversion to the CPT Coding System, which started in the planning stages in January 1974, is now operational on regular lines of business. We are pleased to report that as of the conversion date of March 15, approximately 25% of the claims received were pre-coded using the CPT System.

Approximately 25% of the claims received were precoded using the CPT System. We hope to see this percentage increase dramatically in the next two or three months.

The CPT conversion occurred simultaneously with the updating of the physician profiles, profile data was brought into conformance with the CPT System wherever possible. Based on the charge data accumulated in the next few months, the profiles will again be updated in September. At that time, usual charges will be established according to the CPT Codes used most frequently.

To assist medical office personnel in submitting claims to Blue Shield of Iowa, mini-versions of CPT were developed and distributed. These are simply listings of the most commonly billed procedures for a particular speciality. In addition, in order to acquaint physicians' office personnel with the new coding procedure, our Physicians Relations Department scheduled area training programs for medical secretaries, explaining the five digit plus modifier system.

We have requested permission from the federal government to use the CPT Coding in processing Medicare claims. However, we have been notified the government is not entertaining any proposals for conversion to new coding systems. At some time in the near future we will be sent criteria to use for justifying a new coding system and, accordingly, intend to measure our CPT System against these criteria.

We are convinced the long term benefits of the CPT System will justify the conversion cost and the considerable effort which has been involved in the project's development. We renew our pledge to work with the Iowa Medical Society to foster wide use of the system and commend physicians for their leadership in the implementation of the program.

On September 15, 1974, Blue Shield of Iowa implemented a program of statewide customary by specialty profile with only the University of Iowa Medical complex being considered a separate area. This action was based on review and recommendations by the IMS House of Delegates, the IMS Subcommittee on Medical Review and the Iowa Foundation for Medical Care, all of whom agreed that a statewide customary by specialty profile is a more equitable approach to the determination of customary charges. Previously, profiles were computed according to eight geographic areas in the state.

In order to determine and maintain accurate profiles, both usual and customary charges are updated on March 15 and usuals only are again updated on September 15. These profiles are built from actual charges submitted to Blue Shield.

One major difference between Blue Shield UCR and government program profiles is the recognition of a filed fee schedule. The government programs do not allow profiles to be updated in this manner. In our system, however, one filed fee schedule per procedure per calendar year is allowed in addition to the two computed updates. The filed fee will be effective according to the date on the schedule and will be recognized as the new usual fee.

In another matter related to the efficient delivery of health care, Blue Shield of Iowa is involved in the development of a uniform claim form. To receive reimbursement from Blue Shield of Iowa, Title XIX and Medicare Part B, physicians currently must bill on the proper claim form. In response to a recognized need for a uniform claim form, representatives from the American Medical Association, the Health Insurance Association of America, the National Association of Blue Shield Plans and the Department of Health, Education and Welfare studied the possibility of developing a claim form which could be used by all programs, consequently, a prototype form has been developed and is under study by the Blue Shield Claims Department. Based on the conversion to CPT Coding in Claims Processing, we are assessing the claim form according to the processing requirements of our system. The new form allows only a small amount of latitude for individual system adaptions.

The uniform claim form affords numerous advantages to Blue Shield of Iowa and to physicians. First, the claim form presents obvious billing conveniences for doctors. Because claims submitted to Blue Shield of Iowa on the doctor's own billing form must be transcribed to our form, the uniform claim form would save processing time. Second, a uniform claim form would require that billing personnel become familiar with only one form for the various programs, thus guaranteeing more accurate claims information. And, third, because the benefits provided by one program are often contingent upon those of another (that is, one program may be the primary provider of benefits while another pays deductibles or coinsurance), the total benefit payments, even though made through two separate programs, could be handled by one claim application. The Social Security Administration has tentatively approved the form for Medicare Claims, pending Blue Shield of Iowa's acceptance.

In relating the accomplishments of the past year, we are particularly thankful to the physicians who have contrib-

uted immeasurably to the success of Blue Shield operations through their service on our Provider Relations and Medical Advisory Committees.

The Provider Relations Committee is composed of three members each from the Blue Cross and Blue Shield Boards, the Executive Director of Blue Shield of Iowa, the President of Blue Cross of Iowa, and the Vice President of Provider Relations. Meetings are scheduled quarterly and as needed.

The Provider Relations Committee functions to assure the plans' understanding of Providers' priorities and to review and recommend to the Board and Management Committee strategies to upgrade provider services. The committee also studies and recommends changes in reimbursement policies to assure equitable and timely reimbursement at minimum cost.

The Medical Advisory Committee is composed of six physicians from the Blue Shield Board, which is elected by Blue Shield participating physicians. The function of this committee is to review the medical policies of Blue Shield of Iowa, to evaluate new medical or surgical procedures and to recommend improvements in the efficient delivery of health care and coverage benefits.

Two areas in which the committees provided valuable direction and input during the past year were the CPT Coding Conversion and the establishment of UCR profiles on a statewide customary by specialty basis.

In order to develop stronger consumer input, we reported last year on the organization of 12 Blue Cross and Blue Shield of Iowa Area Subscriber Advisory Committees and a State Subscriber Advisory Council. Topics discussed by advisors during the past year include Reject Letters, Benefit Language, Cost Containment Measures and Alternate Delivery Systems. In addition, the Major Medical claim form was revised by the advisors and preliminary measures of acceptability indicate that the form, which was used by approximately 42% of the subscribers filing for 1974 benefits, is working well. Moreover, the claims load for Major Medical in January and February of 1975 increased about 27% over the same two months of 1974.

In conjunction with the work of an In-House Letter Revision Committee, advisors studied and evaluated reject letters generated by the Claims Department in an attempt to make them more understandable to subscribers. In effect, the advisors were able to "pre-test" the communications potential of the letters before they were sent to subscribers in actual claims reject cases.

Blue Cross and Blue Shield of Iowa have invested manhours and financial resources in an effort to assure the effectiveness of the consumers' input to plan management. During 1974 approximately 300 hours of staff time have been devoted to the advisory committees. This effort is seen as one aspect of Blue Shield of Iowa's commitment to remain accountable to the public it serves.

In conclusion, let me re-emphasize my appreciation to the House of Delegates and all members of the Iowa Medical Society for their support and contributions to Blue Shield of Iowa's accomplishments. Although we are pleased with the many achievements of last year, we must request your continued support in the future. Because we cannot rest on past merits, Blue Shield of Iowa intends to continue and to increase its efforts to be responsive to the health care needs of the Iowa public today and to plan for future priorities. To do less would be contrary to our original objective to provide the best in health care services at reasonable cost to the people of Iowa.

*(Resumption of the report by Dr. Bishop.)*

**CONCLUDING REMARKS**

In concluding this 1975 Supplemental Report of the Board of Trustees, let me urge you to discuss it—and all other items being submitted to the House for its consideration—with your colleagues when you return home.

Tell them that the officers and the 200 physicians who are actively involved in various committee work and other programs of the Society are doing their very best to serve the interests of the profession and the public.

If they are members of the Iowa Medical Society, tell them how much we appreciate their support and confidence.

And if they are not members, tell them if they wish to have a say about the future of the profession in this state and country, they can be more effective within the organization, than out of it.

J. F. BISHOP, M.D., *Chairman*
A. J. HAVLIK, M.D.
J. H. KELLEY, M.D.
R. L. WICKS, M.D.
V. L. SCHLASER, M.D.
T. E. KIERNAN, M.D.
W. R. BLISS, M.D.
T. A. BURCHAM, M.D.

*At the conclusion of the Board report, Dr. Bishop recognized Donald L. Taylor for his 27 years of service to the Iowa Medical Society and announced a dinner would be held in his honor in connection with the July meeting of the IMS Executive Council. Dr. Bishop then presented a check for $13,308.71 to Dr. Paul Seebohm, Executive Associate Dean of the U. of I. College of Medicine. Dr. Seebohm acknowledged the gift and expressed appreciation to the Iowa Medical Society for its support of medical education.*

## INFORMATIONAL REPORT ON THE SCANLON MEDICAL FOUNDATION/ IOWA MEDICAL SOCIETY

Presented by J. F. Bishop, M.D.,
President, Scanlon Medical Foundation/Iowa Medical Society

The following highlights of the medical student loan program of the Scanlon Medical Foundation/Iowa Medical Society are provided for the information of the 1975 House of Delegates:

- There are 12 Iowans receiving medical student loans this 1974-75 academic year. The sharp drop from 43 loans in 1973-74 is caused by availability of funds. The current recipients, their hometowns and their classes are contained with this report.
- The medical student loans made between 4/1/74 and 4/1/75 totalled $24,065. The money repaid during this period by loan recipients now in practice amounts to $6,768.66
- The money loaned by the Foundation since the program began totals $568,384.52.
- The loaned amount which has been repaid is $251,711.02; the amount outstanding is $316,673.50.
- There have been 310 Foundation loan recipients and 167 of them have repaid their loans in full.
- Total resources on loan to the Foundation from physicians, county medical societies and specialty organizations is $54,386.43.

In 1973, the House of Delegates authorized a voluntary entry of $35 on the IMS dues billing statement. This has produced $12,825 for the Foundation during this dues year. Support in this manner is essential to the Foundation.

Another principal source of funding for the Foundation since 1966 has been the Henry Albert Trust. Proceeds from this trust in 1974 amounted to $10,305.53.

Several projects of the Foundation, in addition to the loan program, have been continued, e.g., Hawkeye Science Fair, Henry Albert Scientific Presentation, etc. The funding for these are noted in the financial report.

The SMF/IMS Board of Directors will meet during this session of the House of Delegates to consider the status of the Foundation. The men who now serve on the Board are L. H. Jacques, M.D., G. L. Baker, M.D., A. J. Havlik, M.D., J. H. Kelley, M.D., J. F. Bishop, M.D., R. H. Flocks, M.D., K. E. Lister, M.D., Ronald V. Saf, Ivan Johnson and D. L. Taylor. They will welcome any comments or suggestions which you may have about the Foundation. We are pleased to observe that for the first time medical students sit as official delegates in the House, and we hope they will transmit to their fellow students the desire of the Foundation to assist financially to the extent that our resources will permit.

SCANLON MEDICAL FOUNDATION/
IOWA MEDICAL SOCIETY
1974-75 STUDENT LOAN PARTICIPANTS

| STUDENT | HOMETOWN | JUNIOR | SENIOR |
|---|---|---|---|
| Evans, William Beaty | Davenport | | X |
| Herbst, John W. | Marion | X | |
| Life, Jeffry S. | Iowa City | | X |
| Luepke, Brian Francis | Emmetsburg | X | |
| McCabe, James E. | Burlington | X | |
| McGuire, Michael Hugh | Cushing | | X |
| Munyon, Thomas G. | Des Moines | | X |
| Nassif, Edward G. | Cedar Rapids | | X |
| Rogers, John Charles | Webb | | X |
| Schoell, John E. | Burlington | | X |
| Schultes, Robert J. | Templeton | | X |
| Sexton, Mark Edward | Des Moines | | X |

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY
BALANCE SHEET—DECEMBER 31, 1974

| | | |
|---|---|---|
| ASSETS: | | |
| Iowa State Bank & Trust Company | $ 700.82 | |
| Central National Bank & Trust Company | 8,279.21 | |
| CNB Golden Passbook Savings | 5,001.95 | |
| Notes Receivable from Medical Students | 312,580.16 | |
| Student Nurse Loan Fund | 3,701.63 | |
| Total Assets | | $330,263.77 |
| LIABILITIES AND NET WORTH | | |
| Notes Payable to Physicians & County Medical Societies | $ 54,386.43 | |
| Notes Payable to IMS | 6,000.00 | |
| Net Worth: | | |
| Balance 1-1-74 $253,385.92 | | |
| Add: Net Gain for 1974 16,491.42 | 269,877.34 | |
| Total Liabilities and Net Worth | | $330,263.77 |

SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY
INCOME AND EXPENSE STATEMENT—DECEMBER 31, 1974

| | | |
|---|---|---|
| INCOME: | | |
| Contributions and Memorials | $ 18,846.13 | |
| Henry Albert Trust | 10,305.53 | |
| Interest on Loans | 2,233.06 | |
| Interest on CNB Golden Passbook Savings | 402.35 | |
| The Prouty Company | 250.00 | |
| Total Income | | $ 32,037.07 |
| EXPENSES: | | |
| *Public Service Projects—* | | |
| Hawkeye Science Fair | $ 3,975.00 | |
| *Medical Education Projects—* | | |
| Monthly Scientific Articles in IMS JOURNAL | $ 2,000.00 | |
| Iowa Chapter, Student AMA | 500.00 | |
| Baldridge-Beye Lecture (IMS Scientific Meeting) | 527.22 | |
| *Administrative—* | | |
| Iowa State Bank & Trust Company | $ 400.00 | |
| Interest Paid on Loans from Physicians | 1,549.10 | |
| 1974 Consulting and Staff Services | 5,000.00 | |
| Legal Services | 1,363.00 | |
| Audit and Tax Return | 125.00 | |
| Miscellaneous Administrative Expenses | 106.33 | |
| Total Expenses | | $ 15,545.65 |
| Net Gain for 1974 | | $ 16,491.42 |

# Supplemental Reports of Standing Committees

## NECROLOGY COMMITTEE

(The Speaker asked the members of the House of Delegates to stand while J. E. Tyrrell, M.D., Chairman of the Judicial Council, read the names of IMS members who died in 1974. The list appears on page 275 of this issue of the JOURNAL.)

## NOMINATING COMMITTEE

The Nominating Committee of the Iowa Medical Society met on Sunday, March 23, 1975, and agreed upon the following slate to be presented to the House of Delegates today.

| | |
|---|---|
| President-Elect | James F. Bishop, M.D., Davenport |
| Vice President | James W. White, M.D., Dubuque<br>Craig D. Ellyson, M.D., Waterloo |
| Secretary (3 year term) | William R. Bliss, M.D., Ames |
| Treasurer (3 year term) | Thomas A. Burcham, M.D., Des Moines |
| Speaker of the House of Delegates | Lynn D. Caraway, M.D., Amana |
| Vice Speaker of the House of Delegates | Robert D. Whinery, M.D., Iowa City |
| Trustee (3 year term) | Enfred E. Linder, M.D., Ogden<br>Hormoz Rassekh, M.D., Council Bluffs<br>Daniel M. Youngblade, M.D., Sioux City |
| Delegate to AMA (2 year term) | Christian E. Radcliffe, M.D., Iowa City |
| Alternate Delegates to AMA (2 year term) (3 to be elected) | John R. Anderson, M.D., Boone<br>John M. Rhodes, M.D., Pocahontas<br>John R. Scheibe, M.D., Bloomfield |
| Councilor, 3rd District (3 year term) | Donald F. Rodawig, M.D., Spirit Lake |
| Councilor, 5th District (3 year term) | Clarence H. Denser, Jr., M.D., Des Moines |
| Councilor, 10th District (3 year term) | James D. Kimball, M.D., Osceola |
| Blue Shield Liaison Delegates to IMS (2 to be elected) | Cecil W. Seibert, M.D., Waterloo<br>Jackson Ver Steeg, M.D., Des Moines<br>Edwin A. Motto, M.D., Davenport<br>John R. Scheibe, M.D., Bloomfield |

Additional nominations may be accepted from the floor after which the Speaker of the House of Delegates will declare nominations closed.

The Articles of Incorporation and By-Laws require that for candidates to be unopposed for nomination they must be unanimously approved by the Nominating Committee. Although it is recognized that it is desirable to have two candidates as a minimum for each of the proposed offices, the Nominating Committee is submitting but one candidate for some offices since these were the only names formally proposed to the Nominating Committee and were unanimously approved by the Nominating Committee.

It will be noted that there are four candidates for the two offices of Blue Shield Liaison Delegate to the Iowa Medical Society. Under the Articles of Incorporation and By-Laws of the Iowa Medical Society, the Liaison Committee shall submit to the Nominating Committee the names of four or more candidates for the two positions of Liaison Delegate. Therefore, under the IMS By-Laws, it is mandatory that four or more names be submitted to the Nominating Committee for these offices. These names are merely received by the Nominating Committee and sub-

mitted as a part of its report to the House of Delegates.

Respectfully submitted,
J. L. GARRED, M.D., *Chairman*
J. W. BARNES, M.D.
L. E. COPPOC, M.D.
L. O. GOODMAN, M.D.
C. JONS, M.D.
J. D. KIMBALL, M.D.
G. C. MCGINNIS, M.D.
G. T. SCHMUNK, M.D.
J. X. TAMISIEA, M.D.
D. J. WALTER, M.D.
G. H. WEST, M.D.

*Nominations from the floor were requested, but none were presented. The report of the Nominating Committee was adopted as presented.*

## COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

(Referred to the Reference Committee on Articles of Incorporation and By-Laws.)

The House of Delegates in 1973 increased the number of AMA alternate delegates from one to three. No provision was made for electing alternate delegates to "staggered terms" as is true for the three AMA delegates. The Committee on Articles of Incorporation and By-Laws recommends that the House of Delegates amend the By-Laws by adopting the following resolution:

*Resolved,* That Section 6 of Chapter III of the IMS By-Laws be amended by striking the following paragraph:

*"In each odd-numbered year, it shall elect three alternate delegates to the House of Delegates of the American Medical Association."*

and inserting the following in lieu thereof:

*"It shall elect alternate delegates to the House of Delegates of the American Medical Association in such numbers and for such terms as the Articles of Incorporation and By-Laws of the American Medical Association may provide."*

The adoption of the proposed amendment would "incorporate by reference" the same provisions for alternate delegates as has been in effect for many years with respect to the regular delegates to the AMA.

The Committee further recommends that this House of Delegates agree that the AMA alternate delegate receiving the largest total vote for election as an AMA alternate delegate in 1975 would serve an initial two-year term and the other two remaining AMA alternate delegates will be elected for a one-year term. Such a procedure would make the election of AMA alternate delegates coincide with the election of AMA delegates; for example, in 1975, one delegate to the AMA will be elected for a two-year term. In 1976, two AMA delegates will be elected for two-year terms. The AMA alternate delegates elected for a one-year term in 1975 will thereby need to run for election for a two-year term at the Annual Meeting in 1976. There would be no change in the term of office for delegates and alternates to the AMA, such term now commencing on January 1 of the year following their election.

Respectfully submitted,
K. J. JUDIESCH, M.D., *Chairman*
J. F. BISHOP, M.D.
R. J. DAWSON, M.D.
T. M. GARY, M.D.
P. J. LEEHEY, M.D.
H. J. SMITH, M.D.

*At this point the chair ruled and the House of Delegates accepted the ruling that the elected alternate delegates have the length of their terms (one or two years) determined by the Board of Trustees on a lot or other basis.*

## MEDICO-LEGAL COMMITTEE

(Referred to the Reference Committee on Legislation and Medical Service.)

The Medico-Legal Committee met April 17, 1975 to review the medical liability situation. A summary of the meeting was reported to the membership in an April 21 News Bulletin.

Because medical liability developments are occurring daily, if not hourly, this supplemental report will need to be up-dated in an ad-lib fashion at the time of the House of Delegates.

The availability of liability insurance for Iowa physicians continues to be extremely limited and the premium cost continues to increase. Coverage renewal problems have surfaced recently and have received widespread media attention. The publicized situation in Marshalltown has been relieved apparently for a year's time with the provision of acceptable coverage by the Aetna Life and Casualty Company. However, Aetna has said it does not necessarily plan to extend coverage to other of the anesthesiology groups faced with renewal situations in the next few months.

There is essentially no availability of coverage for new physicians wishing to establish independent medical practices in Iowa. The St. Paul and Aetna report they are extending coverage to new physicians joining their groups. The State's major liability insurer, Medical Protective, is not offering coverage on any basis at this time. In instances where new physicians have become associated with Medical Protective-covered groups, the situation has been made complicated and left legally in doubt. The Professional Mutual Company of Kansas City offers a potential market for physicians who are new in Iowa. There have been isolated instances where Aetna and one or two other companies have consented to accept the coverage of a new physician. This has usually occurred after extensive exploration of the situation by the company, the Insurance Department, the IMS and the involved physician.

The matter of "claims-made" coverage remains in the offing. Indications from the State Insurance Commissioner and others are that this will be the only type of coverage available within a short period of time. Claims-made has provisions which are of concern, e.g., the rate uncertainty, purchase of the tail, consent to settle. The concept has been reviewed with St. Paul officials and they appear adamant in their intention to operate only under this system. Medical Protective has advised it expects to submit a "modified-occurrence" form to the Insurance Commissioner which will be similar in nature. It apparently will make some allowances for taking care of the tail at the time of a physician's retirement.

It is anticipated that matters pertaining to availability, cost and form of coverage will be reviewed by several speakers at the opening session of the House of Delegates. These subjects will also be discussed as desired at the afternoon reference committee hearing.

The Medico-Legal Committee, with appropriate and good input from the Committee on Legislation and the Board of Trustees, has been and is concentrating its efforts in three basic areas: (1) Short-Term Relief, (2)

Long-Term Solutions, and (3) Direct IMS Involvement in a Coverage Program. We will describe briefly the activity in each area:

1) *Short-Term Relief:* As has been stated, there is virtually no market for medical liability insurance at this time. It is the short-term objective of the IMS, the State Insurance Department and others to alleviate this problem. To this end, the Society has devoted a principal amount of its time over the past month or more to seeking the passage of remedial legislation. In January the IMS Executive Council authorized the Legislative and Medico-Legal Committees to present the Iowa General Assembly with various legislative measures and to "stress the public consequences of the problem," and to urge the Assembly "to weigh seriously the passage of some or all of these measures."

As this is written, and as was reported in the recent IMS News Bulletin, the Commerce Committee of the House of Representatives has approved by a vote of 11-3 a package bill which contains several of the Society measures. The bill includes the following provisions:

- That the Insurance Commissioner be empowered to implement a *Joint Underwriting Association* (JUA). Participation in the JUA would be required of all Iowa-licensed casualty insurors. The two-year program is to assure the temporary availability of coverage and is triggered by the Commissioner when he decides no voluntary medical liability insurance market exists.
- That the announcement of stated dollar amounts in petitions for damages shall not be permitted; this is referred to as *elimination of the ad damnum clause.*
- That a claimant not be allowed to receive in any damage settlement payments for health care expenses which have previously been paid by health insurance; this is known as the *collateral source rule.*
- That *Peer Review Immunity* be granted to physicians (and other providers) who perform peer review in good faith.
- That a sliding percentage scale be established to guide the court in determining the *contingent fee* to be paid the plaintiff's attorney.
- That *medical liability panels* (by judicial district) be created to include a judge and two physicians to screen claims with findings admissible as evidence in any litigation.

A revision in the statute of limitations was proposed and defeated in the House Commerce Committee. The Society continues to believe a modification is most important here and is pursuing amendment possibilities. The present law requires action within two years of discovery of an alleged negligent act. The IMS proposal is for a limitation to two years from the time the claimant knew, should have known, or was informed of the injury, or in no event more than four years from occurrence.

The Society has followed the legislative developments in the contiguous and even more distant states. Several states have enacted or have under consideration legislation similar to that in Iowa, several have adopted more extensive provisions, and several must await a subsequent or 1976 session of their legislature.

The need for remedial legislation in Iowa is great and the Society is seeking passage of the current package with full vigor, but also in the face of some active opposition. Our efforts to gain supporters from various ranks have been productive; we have said and written on many occasions that physician contact with legislators is essential if a passage of the legislation is to occur. We reiterate and underscore this fact here.

2) *Long-Term Relief:* The ability of our traditional tort system to remain responsive to the increasingly heavy demands of our litigation-conscious society is in serious doubt. Under consideration across the country are various modifications in or alternatives to the present jury approach to the determination of medical liability and to the assessment of damages. The approaches include arbitration, patient compensation programs, (a la workmen's compensation), no fault, etc. In this regard, it appears likely the General Assembly will order an interim study to examine those options which will provide more long-term relief in the interest of all Iowans. The Iowa Medical Society has an obvious obligation and need to be involved in any such activity. We must be prepared to provide expertise and full assistance in the pursuit of this study.

3) *Direct IMS Involvement in a Coverage Program:* The IMS Executive Council approved a January recommendation from the Medico-Legal Committee that a study be made to assess the feasibility of a group professional liability insurance program from Iowa physicians. This study is moving forward with reasonable dispatch. The project is being undertaken in cooperation with Rollins Burdick Hunter Company of St. Louis, a multi-national insurance broker. Mr. Tim Danis of the Rollins Burdick Hunter Company is expecting to be present at this House session and will be prepared to comment at the hearing of the reference committee to which this report is referred.

The possible advantages of a program of this type are significant; there are also some definite risks which must be weighed. As reported to the Executive Council in January, it is contemplated that any such program would include the following features:

- A stable long term source of coverage for IMS member physicians.
- The development of a specialized claims administration system employing one or more malpractice claims specialists as advisors to any member who reports an incident.
- The collection of and analyzing of loss data to be used in the future for remedial action to prevent claims and to structure underwriting philosophy.
- Consistent legal advice from one or more firms on retainer to act in behalf of the members.
- The promotion of loss prevention programs based on both injury and claim prevention techniques which would be applicable to the members in various classes.
- Availability of a professional broker able to search out every possible market potential in the world and to analyze and follow market trends.

It is heartening to note that Rollins Burdick Hunter has initiated a program this month with the Missouri State Medical Association. They have expressed optimism about having a specific program for further consideration by the Iowa Medical Society within 60 to 90 days. Action will need to be taken at that time to accept, reject or modify any proposal; direction from the House on this possibility may be in order at this time.

It should be reported the investigative phase of this project has included a survey of Iowa physicians. This was distributed April 8. A phenomenal survey return resulted and we now have responses covering 1,675 physicians. The surveys are being analyzed by Rollins Burdick Hunter.

This represents a status report on the activity of the Medico-Legal Committee. We are grateful to the large number of individuals and organizations who are interested in and concerned over this acute problem. We include

here State Insurance Commissioner William Huff and his associate, Laura Sullivan; a large number of state legislators; numerous representatives of the insurance industry; and many of the other health care providers. We stand ready to elaborate on this subject as desired at the hearing of the reference committee. Finally, we will welcome the encouragement and further direction of the House of Delegates. We urge the members of the House to review the information presented at this session with your medical colleagues at home.

Respectfully submitted,
C. H. DENSER, JR., M.D., *Chairman*
G. H. ASHLINE, M.D.
K. K. HAZLET, M.D.
R. P. LAGONI, M.D.
R. A. MANDERSCHEID, M.D.
M. D. RAVREBY, M.D.
E. D. THOMPSON, M.D.
J. M. TIERNEY, M.D.
W. V. WULFEKUHLER, M.D.

*Dr. Donald C. Young, chairman of the IMS Committee on Legislation, presented an oral report from the Committee on Legislation for delegates' information only, and Jim West, IMS legislative counsel, also addressed the Assembly.*

## SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

In 1974 the House of Delegates endorsed a disease eradication program devised by the Iowa State Department of Health in coordination with the Subcommittee on Maternal and Child Health. Implementation of the program this year has involved the appointment of immunization chairmen by approximately 35 county medical societies. Informational material has been sent to these chairmen and, as this is prepared, a one-day immunization seminar is planned in late May for these and other interested physicians.

This supplemental report is provided basically for the information of the House. There have been several outbreaks of measles (rubeola) in recent weeks in various parts of the state. These have been brought to the attention of the county medical societies by the Subcommittee on Maternal and Child Health through the distribution of the following memorandum. It is submitted again at this time in the hope all IMS delegates will assure that adequate local effort is being made by their county medical societies to eradicate all immunizable diseases to the fullest extent possible.

*To:*
Presidents, County Medical Societies
County Society Immunization Chairmen
Physician Members, Local Boards of Health

*From:*
George L. Baker, M.D., Chairman
Committee on Maternal and Child Health
Iowa Medical Society

*Subject:* Increasing Incidence of Measles (Rubeola)

This communication is intended to relay and support the genuine concern of the State Department of Health (SDH) over the recently reported outbreaks of measles. These 1975 reports have come from Council Bluffs in Pottawattamie County, Nora Springs in Floyd County, Riceville in Mitchell County, Waterloo in Black Hawk County and Des Moines in Polk County. Suspected cases have also been reported in Allamakee County.

The SDH believes this current incidence of measles is part of a trend best described as "measles in the post-vaccine era." This first came to light in the Burlington-Des Moines County area in 1971. Six counties have noted measles outbreaks during the 1974-75 school year. And it is expected by the SDH Infectious Disease Control Section that other counties, where no active catch-up immunization program is operative, may experience school-centered measles in the near future.

Outbreaks to date (1) have been school-centered, (2) have primarily affected children not previously vaccinated for measles, and (3) have spread to susceptible preschool children and to children in other schools or systems. A few cases of measles have appeared in school children vaccinated prior to one year of age or in children given vaccine with gamma globulin, as was recommended in the early years of vaccine availability.

The SDH recommends local consideration of the following steps in preventing any near-future reappearance of measles.

1. Identify all children in schools who have neither received measles vaccine nor suffered clinical measles by history.
2. Identify all school children who received measles vaccine before one year of age and/or in association with gamma globulin. In general, measles vaccine given prior to 1968 may be considered to have been gamma-globulin-associated.
3. Administer measles vaccine in the schools to all pupils so identified.
4. Provide measles vaccine to all preschool children more than 12 months of age, who have not already been vaccinated.
5. Establish an annual procedure to assure that all children entering school have had measles and other recommended vaccines.

Various successful local approaches have been followed in providing immunizations. Support is often available from county health departments, public health nurses, school nurses and school administrators, service organizations and news media. The Immunization Program of the State Department of Health will be happy to advise and assist in local efforts; this support has been provided in numerous counties during the past three years.

The Iowa Medical Society has supported and endorsed the SDH in its efforts to encourage local immunization activity. The IMS Committee on Maternal and Child Health is available, along with the SDH, to provide its medical expertise. Please write or call Society Headquarters if you desire specific information.

Respectfully submitted,
G. L. BAKER, M.D., *Chairman*
W. J. BALZER, M.D.
D. D. FABER, M.D.
CHARLOTTE FISK, M.D.
L. Z. FURMAN, M.D.
R. E. HEDICAN, JR., M.D.
J. L. KEHOE, M.D.
D. O. NEWLAND, M.D.
C. W. STEVENS, M.D.
J. M. WALL, M.D.
J. J. WEYER, M.D.

# Supplemental Reports of Special Committees

## COMMITTEE ON DRUG ABUSE

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

In response to a recommendation of the Drug Abuse Committee that it be authorized to conduct a study to assess the real or imagined problems related to the misuse and abuse of licit drugs, the 1974 House of Delegates directed the committee to submit a report to the House in April, 1975 regarding the feasibility and propriety of conducting a data collection survey on the drug prescribing practices of physicians, with specific reference to the cost of undertaking such a study, the mechanics to be used in implementing it, and obtaining necessary assurance for maintaining control over the use of information gained from the study.

In response to the action of the House of Delegates, representatives of the committee met last fall with Jean Gagnon, Ph.D., Professor of Pharmacy Administration at the University of Iowa College of Pharmacy, to discuss the possible implementation of the proposed data collection survey by the IMS. Doctor Gagnon noted that several studies concerning the prescribing practices of physicians have already been made in which special attention was given to the effect of quality and frequency of prescription upon price, and the relationship between physician characteristics and scripting habits—i.e., age, location, specialty, etc. He provided to the committee copies of papers reporting on these studies.

At the meeting last fall, Doctor Gagnon also advised that the College of Pharmacy has raw computer data available on approximately 27,000 prescriptions, from which information relating to frequency, duration, quantity, quality, refills, dosage, cost and selling price could be extracted. The prescriptions were obtained from 100 pharmacies in Iowa for a study requested and financed by the State Department of Social Services. The study was conducted for the purpose of determining prescription costs and mark-up.

As a result of the initial conference with Doctor Gagnon, information was extracted from the existing raw computer data regarding psychotropic drug prescriptions. A copy of a report compiled by Doctor Gagnon, consisting of a series of statistical tables, was provided to the committee members.

In reviewing the tables, it is noted that out of the total of 27,000 prescriptions analyzed, 4,276 were for psychotropic drugs, which included 216 brand name products. The summary statistics developed by Doctor Gagnon concern the most frequently prescribed psychotropic drugs dispensed in 100 Iowa pharmacies—i.e., Valium 5 mg; Valium 2 mg; Librium 10 mg; Empirin #3; Lomotil; Librax; Dalmane 30; Fiorinal; Equagesic; Equanil 400; Elavil 25; Librium 5; Percodan; Tylenol with Codeine #3; Valium 10.

In light of the statistical data that has been provided to and studied by the Committee on Drug Abuse, as well as the availability of additional raw computer data through the U of I College of Pharmacy, the Committee on Drug Abuse respectfully makes the following request of the House of Delegates:

1. To authorize the Committee on Drug Abuse, in joint effort with Doctor Gagnon, to prepare an article for publication in the JOURNAL OF THE IOWA MEDICAL SOCIETY which would present the statistical data on the 15 most commonly prescribed psychotropic drugs dispensed in 100 Iowa pharmacies. This information could also be used as the basis for lecture presentations at scientific meetings and other scientific endeavors of the IMS.

2. To authorize the Committee on Drug Abuse to confer with representatives of the Iowa Pharmaceutical Association regarding the feasibility of undertaking an evaluation study to determine whether or not the presentation of information and statistics on the use of the 15 psychotropic drugs has influenced the prescribing practices and patterns of physicians insofar as the future use of these drugs is concerned. After a specified period of time following publication of the proposed JOURNAL article and lectures, appropriate data would be collected from pharmacists concerning psychotropic drug prescriptions so that it could be analyzed and compared with the statistics contained in the Tables presently available.

It has been estimated that the cost of conducting an evaluation study might approximate $3,000; however, this amount could be substantially reduced if appropriate arrangements can be made with the IPhA—e.g., contacting a selected group of pharmacists to participate in the study and provide prescription data on a voluntary basis.

In seeking this authority, the committee emphasizes that:

1. It would present a progress report to the House of Delegates in 1976 regarding the evaluation project, and approval would be requested with respect to the use of any data collected or conclusions drawn from the evaluation study.

2. It is the desire of the committee that the medical profession demonstrate its willingness to assume and maintain responsibility for defining educational needs and implementing appropriate educational programs relating to drug prescribing practices of physicians, thus avoiding further restrictions on the use of prescription drugs via federally imposed rules and regulations.

Respectfully submitted,
F. W. BENNETT, M.D., *Chairman*
H. A. MAHANNAH, M.D.
R. W. OVERTON, M.D.
C. E. RADCLIFFE, M.D.
J. F. STILES, M.D.
K. H. STRONG, M.D.

## COMMITTEE ON HEALTH CARE IN CORRECTIONAL INSTITUTIONS

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

In 1974 the Iowa Medical Society House of Delegates acknowledged the evaluation made by the Committee on Health Care in Correctional Institutions of the medical facilities and services in the four state-operated correctional institutions. The 1974 House of Delegates approved nine resolutions based on recommendations submitted by the Committee following its visitations to the state facilities. These resolutions subsequently have been transmitted to the superintendents of the state facilities, to the Bureau of Corrections of the State Department of Health, and to the American Medical Association.

A tenth resolution was approved by the 1974 House of Delegates:

"*Resolved,* That the Iowa Medical Society consider the continuation of this or a similar committee to assess and report on health care provisions in city and county jails in Iowa. It is believed that county medical societies could provide valuable support to a state committee in an evaluation of this type."

The Committee on Health Care in Correctional Institutions has devoted time to the assignment noted in this resolution. A three-page survey with covering letter was sent in January to all county sheriffs and to selected municipal police chiefs. One hundred and ten surveys were distributed. Sixty-three questionnaires were returned. The survey was sent to county society presidents with an informational letter.

In contrast to the preceding year's fairly extensive assessment of the state-operated penal facilities with the resulting comprehensive tabular report, the 1974-75 evaluation of the county and municipal jail facilities was notably more difficult because of the varying and less well-defined provisions for medical services. Obviously, provisions exist for routine and emergency medical services in jails with direct relation to the size of the community or county.

While some survey responses were difficult to interpret and some provided only minimal information, the following observations are possible based on our evaluation of the questionnaires:

1. Health care capability within local detention facilities is basically of the first aid type. Seventy-four percent of the respondents indicated having first aid only; 8% reported having an examining room; 6% advised that they have a clinic/dispensary.

2. Virtually no in-house facilities were reported as being available for specialized care. Fewer than 12% reported having any special facilities for acute care, chronic care, mental care, drug addiction or alcoholism. Local or nearby facilities were often cited as being available for these services.

3. The number of jail inmates receiving medical care per month is extremely small. An average of fewer than five prisoners per facility were reported as being seen by physicians per month with the exception of the several larger counties.

4. Use is made as necessary of the traditional and available health care facilities. Usage of the following was reported: physician's office (37), medical clinic (27), psychiatric facility (25), government hospital (city, county or state) (31), private hospital (24), and University hospital (12).

5. Virtually all physician care is reported to be reimbursed on a fee-for-service basis. Eighty-six percent of those answering this question indicated following this practice.

6. As a corollary to the preceding, almost all responding jails (91%) said they have no formal arrangements with physicians to provide care, they simply arrange for it as needed.

7. No physical examination of inmates is undertaken routinely without the reporting of symptoms, according to the survey.

8. Nearly 100% of the surveys reported regular sanitary inspection of food services, personal hygiene, bathing and toilet facilities, clothing and bedding, and garbage and waste disposals.

9. Pharmaceutical services were reported as being provided as necessary and through a variety of arrangements, with most dispensing done by sheriffs, deputies, or jailers.

The survey presented little information to demonstrate any trends or particular deficiencies in the area of health services. The Committee therefore finds it difficult to draw and submit any firm conclusions or concise recommendations. It is obvious that the infrequent jail mishap or suicide stirs public interest and raises concern over provisions in this area. All reasonable efforts should be undertaken to minimize the likelihood of these occurrences.

With the foregoing background information offered for the review of the House of Delegates, the two following resolutions are recommended for endorsement:

1. *Resolved,* That the Iowa Medical Society House of Delegates encourage the constituent county medical societies (a) to be mindful of the specialized medical care needs of local jails, and (b) to confer periodically with local law enforcement officials to assure these needs are met in an appropriate manner.

2. *Resolved,* That the Iowa Medical Society discharge the committee or maintain it on a standby basis in the event further inquiries are directed to the Society in this area.

Respectfully submitted,
A. P. RANDOLPH, M.D., *Chairman*
C. N. HYATT, M.D.
D. R. KRUSCHWITZ, M.D.
E. C. LAIRD, M.D.
R. M. POWELL, M.D.
W. T. SHULTZ, M.D.
E. M. SMITH, M.D.

## SUBCOMMITTEE ON INTERPROFESSIONAL ACTIVITIES

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

*See bracketed portion of Handbook for House of Delegates material published on pages 281 and 282 of this issue of the* JOURNAL.

## SUBCOMMITTEE ON MEDICAL REVIEW

(Referred to Reference Committee on Legislation and Medical Service.)

*See bracketed portion of Handbook for House of Delegates material published on page 279 of this issue of the* JOURNAL.

## COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

*See bracketed portion of Handbook for House of Delegates material published on page 277 of this issue of the* JOURNAL.

## RESOLUTIONS

### DES MOINES-LOUISA COUNTIES MEDICAL SOCIETY NO 1. RELATIONS WITH COLLEGE OF MEDICINE

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, Many of the private physicians in Iowa, who have formerly been associated with the University of Iowa Hospitals, have observed a prevailing attitude of condescension toward and lack of professional respect for referring physicians and their medical competence; and

WHEREAS, There have been multiple instances of patients referred to University Hospitals reporting back critical comments regarding the local diagnosis and management resulting in many cases in direct and adverse effect on the relation of the referring physician with his patient; and

WHEREAS, In some instances careless and damaging comments to referred patients and families have directly resulted in legal action; and

WHEREAS, The medical malpractice situation has reached critical proportions resulting in compromise of all physicians' ability to provide medical care and in the availability and quality of medical care to the public, therefore be it

*Resolved,* That the Iowa Medical Society work with and urge the University of Iowa College of Medicine to form a formal and continuing program to teach students, interns, residents and staff regarding the importance of supporting the local referring physician and avoiding all careless and damaging comments and attitudes which tend to undermine the confidence of the patient in the local physician, and be it further

*Resolved,* That the Iowa Medical Society urge the College of Medicine to make every effort to develop a better atmosphere of communication, cooperation, and consultation with the local physician in the management of the patient's problem for the improvement of patient care and patient-physician relationship.

### CLINTON COUNTY MEDICAL SOCIETY NO. 2 PSRO OPPOSITION

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, We believe the Professional Standards Review amendment to Title XI of the Social Security Act, enacted as Public Law 92-603, was hastily enacted by the 92nd Congress on the false assumptions (1) that medical care in the United States is of inferior quality, and (2) that physicians are responsible for the increase in cost of medical care; and

WHEREAS, Enforcement of PSRO would destroy the freedom of physicians to exercise independent judgment in caring for Medicare and Medicaid patients by forcing them to conform to government-imposed "norms" of diagnosis and treatment; and

WHEREAS, Standardization of medical care will seriously impair the quality of medical care to the detriment of these patients by restricting a physician's liberty to use his own judgment, skill and knowledge freely; and

WHEREAS, Physicians who deviate from government's arbitrary "norms" will be subject to punishment, no matter how much harm to the patient might result from adherence to the norms; and

WHEREAS, We believe officials of HEW are engaging in a reprehensible misrepresentation of fact when they say local doctors will control PSROs and set the standards of medical practice that PSROs will be required to force upon the practicing physician; and

WHEREAS, We believe that enforcement of PSRO will destroy the confidential nature of the patient-physician relationship, therefore be it

*Resolved,* That all medical organizations that have applied for recognition as a PSRO be asked to withdraw immediately their applications and return any federal funds that have been accepted so that the independence of the medical profession can be carefully preserved, and be it further

*Resolved,* That the Iowa Medical Society and all component societies work vigorously with Iowa senators and representatives in Congress to achieve repeal of the PRSO law, and be it further

*Resolved,* That Iowa delegates to the AMA House of Delegates be instructed to vote for a clear-cut AMA policy to require the Board of Trustees and staff to work vigorously for repeal of PSRO and to cease immediately collaboration with HEW to implement the PSRO law.

### WEBSTER COUNTY MEDICAL SOCIETY NO. 3 PROFESSIONAL LIABILITY

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, The burgeoning increase in medical malpractice claims and settlements has resulted in a manyfold increase in the cost of professional liability insurance, and

WHEREAS, This increase has been and will be reflected in increased cost of medical care to the general public, and

WHEREAS, One of the many contributing causes of this increase, apparently, is a traditional "straight line" contingency legal fee, and

WHEREAS, The statute of limitations is two years from the date of discovery, rather than two years from the date of the act, and

WHEREAS, The Iowa Medical Society Executive Council, on or about January 30, 1975, authorized a legislative program to emphasize the grave public consequences of this situation, and to seek passage by the Iowa General Assembly of one or more of several legislative measures to modify the existing situation, therefore be it

*Resolved,* That the House of Delegates of the Iowa Medical Society wholeheartedly and unanimously support the action of the Executive Council and encourage a rapid and vigorous pursuit of legislative changes, and urge specific emphasis be placed in establishing: 1) A statute of a decreasing, sliding scale of contingency fees, and 2) A statute of limitations of two years from the date of the act or incident as such apply to professional liability tort cases.

### WEBSTER COUNTY MEDICAL SOCIETY NO. 4 ELECTION OF AMA PRESIDENT

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, The American Medical Association has had fluctuations in its effectiveness in influencing and establishing federal policies and legislation as such apply to the practice of medicine, and in particular to the ever-increasing governmental control through such acts as Title XVIII, Title XIX, PSRO, and the probability of NHI, and

WHEREAS, The American Medical Association has recently had a financial crisis, requiring a special assessment from its membership and some curtailment or revision of services, publications and functions in order to regain fiscal soundness, and

WHEREAS, In addition to the universal effects of inflation, the financial problems of the AMA may be in part a result of less than adequate executive management and unnecessary bureaucratic inefficiency, and

WHEREAS, The discontent of many physicians in the nation with the effectiveness of the AMA has resulted in "splinter groups" and a slowly growing number of physicians' unions, and

WHEREAS, The AMA cannot project a national image with consistency because of the annual change in its president, whose many duties include being the spokesman and "leader" of the AMA, therefore be it

*Resolved,* That the House of Delegates of the Iowa Medical Society instruct the Iowa Delegates to the American Medical Association to propose a change in the AMA executive structure so that the President of the AMA is elected by a referendum of the entire organizational membership for a term of four years, and that the salary be commensurate with the position, so that the President can devote full time to his duties, and therefore be more effective as a national leader of our American Medical Association.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 5 ANTI-SMOKING LEGISLATION

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, Smoking is a known definite health hazard, and

WHEREAS, The rights of non smokers to clean air are frequently disregarded by smokers, especially in crowded places, and

WHEREAS, There is legislation pending in the Iowa General Assembly prohibiting smoking in public facilities except in designated areas, therefore be it

*Resolved,* That the Iowa Medical Society actively support such anti-smoking legislation.

DUBUQUE COUNTY MEDICAL SOCIETY
NO. 6 VIEWS OF PRESIDENTIAL CANDIDATES

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, It would be helpful for the delegates in voting for the Iowa Medical Society's highest office holder to know what the candidate plans to accomplish during his term, and

WHEREAS, Some delegates are not familiar with the candidates seeking the office of president, therefore be it

*Resolved,* That each candidate for the presidency address the House of Delegates at the time of his nomination stating what he hopes to accomplish and how he stands on potential issues.

MARION COUNTY MEDICAL SOCIETY
NO. 7 CONTINGENCY FEE SOLUTION

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, The Marion County Medical Society believes the contingency fee system promotes and multiplies unfounded malpractice actions; and

WHEREAS, The fear of malpractice actions is the cause of defensive practice by physicians and hospitals, which is a principal factor in the increased cost of medical care to the public; and

WHEREAS, The contingency fee system, in our society as a whole, fosters unfounded, vengeful civil actions to the detriment of the citizen's tangible and mental rights; therefore be it

*Resolved,* That the Iowa Medical Society present a bill to the Iowa General Assembly which shall provide (1) that the losing party in civil litigation shall not only pay all court costs, but shall in addition pay a reasonable fee to the winning party's attorney; (2) that the poor man shall be able to sue if he has a justifiable case, determined in medical cases by a county committee composed of the county attorney, the president of the county bar association, the president and secretary of the county medical society and the clerk of court. In non-medical cases the committee shall be composed of the board of supervisors, the county attorney and the clerk of court. If either committee finds in its investigation that the poor man has a justifiable case, a unit of the state will provide him with an attorney and the necessary means to comply with the law; (3) that there shall be established in connection with this proposed law a schedule of justifiable fees that the losing party has to pay to the winning party's attorney; and (4) that before any plaintiff can begin civil litigation he must present to the clerk of court an affidavit and additional proof, if the clerk of court deems necessary, showing that he has the means to pay court costs and the defendant's attorney fee; and be it further

*Resolved,* That the Iowa Medical Society actively support this proposal and seek the support of other state organizations which stand to benefit; and be it finally

*Resolved,* That this resolution be submitted to the American Medical Association at its next meeting for its approval as state legislation.

STUDENT IOWA MEDICAL SOCIETY
NO. 8 SCANLON FOUNDATION LOAN FUN

(Referred to Reference Committee on Reports of Officers and Miscellaneous Business.)

WHEREAS, University resources presently meet only one-half of the medical student financial need, and the trend over the last several years would not suggest that a reversal of this critical inadequacy is near, and

WHEREAS, The winds of political and economic fortune ultimately determine to what extent the financial aid pool is replenished, and this contingency contributes to an air of uncertainty which must hinder any thoughtful arrangement for medical education financing, and

WHEREAS, Students, to satisfy an unmet financial need, have increasingly enrolled in service-linked scholarship programs, and that this popularity may be attributable in part to both the presently tight financial outlook and the increased availability of scholarships, and that these programs necessarily militate against a "principal goal of the Society to produce more doctors for Iowa," and

WHEREAS, The Scanlon Foundation Loan Fund is seriously depleted to the extent that only loans to previous recipients will be offered for the coming year, therefore be it

*Resolved,* That the Iowa Medical Society take charge to substantially develop the Scanlon Foundation Medical Student Loan Fund in order (1) that it may lessen the critical inadequacy of the medical student financial aid service, and (2) that it may hope to guarantee the needy student a source of financial sustenance, and (3) that it may contribute to a multiplicity of financial aid sources which would enable a lesser dependence upon service-linked scholarship programs, and (4) that it may again become and remain a significant factor in medical school financial aid.

WRIGHT COUNTY MEDICAL SOCIETY
NO. 9 PSRO

(Referred to Reference Committee on Legislation and Medical Service.)

*Resolved,* That the House of Delegates request that the memberships of all county medical societies be polled regarding their opinion of PSRO now.

JASPER COUNTY MEDICAL SOCIETY
NO. 10 PATIENT BILL OF RIGHTS

(Referred to Reference Committee on Legislation and Medical Services.)

WHEREAS, House File 585 (an Act relating to rights of persons seeking health care), which is now before the Iowa General Assembly, is vague in wording and does not assure or contribute to quality of care, and

WHEREAS, This bill does not insure the patient will understand concepts or diagnostic terminology, and

WHEREAS, This bill would place another governmental obstruction to the practice of medicine, and

WHEREAS, This bill would not appear to be enforceable and therefore would not constitute a "Bill of Rights," therefore be it

*Resolved,* That the Iowa Medical Society go on record as being opposed to this legislation.

BLACK HAWK COUNTY MEDICAL SOCIETY
NO. 11 PROFESSIONAL LIABILITY LEGISLATION

(Referred to Reference Committee on Legislation and Medical Service.)

WHEREAS, The state of Iowa and the nation are faced with a crisis in medical liability insurance availability and cost; and

WHEREAS, This crisis poses a severe threat to the availability of health care in Iowa with the forced early retirement of physicians and/or movement of physicians to states where reasonably priced medical liability insurance is available; and

WHEREAS, If physicians accept insurance with extremely high premiums, this cost must be absorbed by patients in forms of higher fees; and

WHEREAS, Several other states have enacted laws this year to insure availability of reasonably priced medical liability insurance, and have therefore increased their chances of recruiting and keeping an adequate number of physicians in their states; and

WHEREAS, The Iowa General Assembly and the Governor of Iowa have expressed their reluctance to act on this serious matter; therefore be it

*Resolved,* That the Iowa Medical Society set a date and urge *all* of its members to participate in a complete moratorium on all except emergency services after that date and for as long as needed to inform and instruct the public and the elected officials of the crisis in Iowa. Said moratorium on elective services will be lifted only when action is taken by the General Assembly and the Governor to assure the availability of adequate, reasonably priced "occurrence-coverage" insurance, which in turn will permit continued adequate numbers of physicians to remain in Iowa and will encourage new physicians to come to Iowa to practice.

## LIFE AND ASSOCIATE MEMBERSHIPS

LIFE MEMBERSHIPS RECOMMENDED ON THE BASIS OF 50 YEARS' PRACTICE AND THE LAST 15 CONSECUTIVE YEARS' MEMBERSHIP

| County | Name |
|---|---|
| Black Hawk | John L. Kestel, M.D., Waterloo |
| Carroll | Walter A. Anneberg, M.D., Carroll |
| Des Moines-Louisa | Francis H. Aid, M.D., Burlington |
| Iowa | Lawrence A. Miller, M.D., North English |
| Polk | Walter A. Kirch, M.D., Des Moines |
| | Herbert A. Sohm, M.D., Des Moines |
| | Joseph B. Priestley, M.D., Des Moines (Posthumously) |
| | J. Frederick Throckmorton, M.D., Des Moines |
| Scott | Edward F. Kohrs, M.D., Davenport |
| | Carl H. Matthey, M.D., Davenport |
| | Leo J. Miltner, M.D., Davenport |
| Story | John G. Grant, M.D., Ames |
| Woodbury | Roland T. Rohwer, M.D., Sioux City |

The physicians nominated for each of these membership categories were approved unanimously.

The Speaker advised of the time and locations of the several reference committee hearings. It was explained the House would reconvene at 9 a.m. Thursday, May 1, 1975. The opening session was adjourned at 1:10 p.m.

ASSOCIATE MEMBERSHIPS RECOMMENDED ON THE BASIS OF RETIREMENT OR INCAPACITATION

| County | Name |
|---|---|
| Buena Vista | Paul W. Brecher, M.D., Storm Lake |
| Carroll | Leo H. Kuker, M.D., Carroll |
| | Frank W. Reibold, M.D., Carroll |
| Cerro Gordo | Manuel Brownstone, M.D., Clear Lake |
| | Harry G. Marinos, M.D., Mason City |
| Davis | Richard Schoonover, M.D., Bloomfield |
| Decatur-Ringgold | Elmo E. Gamet, M.D., Lamoni |
| Des Moines-Louisa | Robert D. Rowley, M.D., Burlington |
| Dubuque | Ross P. Rusk, M.D., Dubuque |
| Floyd | Norman C. Flater, M.D., Floyd |
| Franklin | Seth G. Walton, M.D., Hampton |
| Hardin | John J. Shurts, M.D., Eldora |
| Kossuth | Melvin G. Bourne, M.D., Algona |
| Linn | Robert M. Chapman, M.D., Fremont, Calif. |
| | Stanley T. Moen, M.D., Cedar Rapids |
| Polk | Ellen Ferengul Anspach, M.D., Mitchellville |
| | Royal S. Anspach, M.D., Mitchellville |
| | Thomas A. Bond, M.D., Des Moines |
| | Jesse H. McNamee, M.D., Des Moines |
| | Arnold L. Nelson, M.D., Huxley |
| Pottawattamie-Mills | Charles V. Edwards, Sr., M.D., Council Bluffs |
| | Frederick E. Marsh, M.D., Council Bluffs |
| Sac | John W. Gauger, M.D., Early |
| Wapello | David O. Holman, M.D., Ottumwa |
| | Wilson C. Wolfe, M.D., Ottumwa |
| Webster | Wilbur C. Thatcher, M.D., Hackensack, Minn. |

## THURSDAY SESSION, MAY 1, 1975

The Thursday session of the House of Delegates was called to order at 9 a.m. The House approved the taking of attendance by registration cards. There were 121 delegates, 20 voting alternates and 13 ex-officio members present. Delegates were provided reference committee reports and ballots at the time of registration.

| COUNTY | DELEGATE |
|---|---|
| Appanoose | A. S. Owca |
| Audubon | R. M. Mason |
| Black Hawk | A. M. Dolan |
| | M. N. Williams |
| | R. E. Hedican, Jr. |
| | R. S. Gerard |
| | W. M. Kelly |
| | R. T. Guthrie |
| | R. R. Roth* |
| | C. D. Ellyson* |
| Boone | E. E. Linder |
| Bremer | G. J. Kimball |
| Buchanan | P. J. Leehey |
| Butler | F. O. Rolfs |
| Calhoun | R. P. Ferguson |
| Cass | T. J. Payne |
| Cerro Gordo | G. H. West, Jr. |
| | R. E. McCoy |
| | D. D. Van Etten |
| | W. C. Rosenfeld |
| | W. G. Garrett* |
| Cherokee | G. E. Michel |
| Chickasaw | P. A. Searles, D.O. |
| Clarke | J. D. Kimball |
| Clay | J. X. Tamisiea |
| Clayton | J. D. Compton |
| Clinton | G. L. York |
| | G. T. Schmunk |
| Crawford | D. J. Soll |
| Dallas-Guthrie | E. E. Lister |
| | N. L. Krueger |
| Davis | H. M. Perry |
| Decatur-Ringgold | D. E. Mitchell |
| Delaware | J. E. Tyrrell |
| Des Moines-Louisa | K. A. Hahn |
| Dickinson | D. F. Rodawig, Jr. |
| Dubuque | J. W. White |
| | R. T. Melgaard |
| | K. K. Hazlet |
| | J. S. Chapman |
| Floyd | E. E. Schmiedel |
| Fremont | F. M. Ashler |
| Grundy | D. R. Kruschwitz |
| Hancock-Winnebago | L. R. Fuller |
| Hardin | T. C. Graham |
| Harrison | J. W. Barnes |
| Ida | J. B. Dressler |
| Jackson | J. A. Broman |
| Jasper | Kim Petersen* |
| Jefferson | K. H. Strong* |
| Johnson | K. J. Judiesch |
| | R. C. Brown |
| | S. W. Greenwald |
| | C. E. Hartford |
| | C. E. Radcliffe |
| | C. A. Skaugstad |
| | R. D. Whinery |
| | K. D. Dolan |
| | P. M. Seebohm |
| | K. J. Printen |
| | W. H. Baker* |
| | J. B. Wilcox* |
| Jones | A. P. Randolph |
| Keokuk | Opas Jutabha |
| Kossuth | J. M. Rooney |
| Lee | G. C. McGinnis |
| | J. E. McGee |
| | R. L. Kent* |
| Linn | R. A. Sautter |
| | C. R. Aschoff |
| | R. W. Conkling |
| | R. J. Barry |
| | J. H. Lohnes |
| | A. C. Hass |
| | W. J. Robson |
| | G. R. Wessels |
| | G. P. Hayes* |
| | J. W. Reinertson* |
| Mahaska | S. A. Smith |
| Marion | P. C. Todd |
| Marshall | L. O. Goodman |
| | W. T. Shultz |
| | R. R. Widner |
| Mitchell | R. G. Boeke |
| Monona | J. L. Garred |
| Monroe | D. N. Orelup |
| Muscatine | K. E. Wilcox |
| O'Brien | R. L. Zoutendam |
| Plymouth | J. P. Trotzig |
| Pocahontas | J. M. Rhodes, Sr. |
| Polk | D. J. Walter |
| | D. C. Young |
| | John Hess, Jr. |
| | J. I. Fatland |
| | M. E. Thoman |
| | R. C. Smith |
| | R. L. Kollmorgen |
| | Marshall Flapan |
| | D. L. Sweem |
| | W. R. Hornaday, Jr. |
| | D. O. Newland |
| | Lester Beachy |
| | L. E. Longnecker |
| | E. J. Laing* |
| | C. H. Denser, Jr.* |
| | G. A. Kern* |
| | B. T. Woodburn* |
| | L. O. Ely* |
| | J. W. Walker* |
| | J. L. Stecher* |
| Pottawattamie-Mills | A. L. Sciortino |
| | G. L. Neligh |
| | M. E. Olsen |
| | J. L. Knott |
| | R. K. Fryzek |
| Poweshiek | H. R. Light |
| Scott | J. C. Barker |
| | A. W. Boone |
| | W. B. Hofmann |
| | R. J. Ketelaar |
| | F. W. Smith |
| | W. F. Ramsey* |
| Shelby | J. H. Spearing |
| Sioux | E. B. Grossmann, Jr. |
| Story | W. R. Bliss |
| | W. A. Baird |
| | C. J. Chapple |
| | Charles Jons |
| Tama | A. J. Havlik |
| Union-Taylor | R. H. Kuhl |
| Wapello | L. E. Coppoc |
| | R. P. Meyers |
| Wayne | K. A. Garber |
| Webster | L. K. Berryhill |
| Winneshiek | L. K. Lamberty |
| Woodbury | D. M. Youngblade |
| | D. E. Howard* |
| Wright | S. P. Leinbach* |
| Student IMS | D. C. Trost |

* Alternate

### LIAISON DELEGATES

C. W. Seibert J. D. Ver Steeg

### EX-OFFICIO MEMBERS OF THE HOUSE

R. L. Wicks
V. L. Schlaser
J. F. Bishop
C. L. Kelly, Jr.
W. V. Wulfekuhler
Hormoz Rassekh
L. D. Caraway
L. W. Swanson
Erling Larson, Jr.
J. R. Scheibe
J. R. Anderson
K. E. Lister
J. H. Sunderbruch

Dr. Bliss read the minutes of the April 30 meeting of the House of Delegates and the House approved them.

The election of officers occurred and the following physicians were chosen:

| | |
|---|---|
| President-elect | J. F. Bishop, M.D., Davenport |
| Vice President | C. D. Ellyson, M.D., Waterloo |
| Trustee (3 year) | Hormoz Rassekh, M.D., Council Bluffs |
| Speaker of the House | L. D. Caraway, M.D., Amana |
| Vice Speaker of the House | R. D. Whinery, M.D., Iowa City |
| Delegate to AMA | C. E. Radcliffe, M.D., Iowa City |
| Councilor, District 3 | D. F. Rodawig, Jr., M.D., Spirit Lake |
| Councilor, District 5 | C. H. Denser, Jr., M.D., Des Moines |
| Councilor, District 10 | J. D. Kimball, M.D., Osceola |

Dr. Caraway thanked the members of the Reference Committees, underscored the importance of this service, and asked the inquiries regarding appointments be directed to the Speaker, IMS Headquarters. He then informed the delegates of the proper procedure for debate and voting on Reference Committee Reports.

## REFERENCE COMMITTEE REPORTS

The following Reference Committee reports were acted upon by the House of Delegates.

## ARTICLES OF INCORPORATION AND BY-LAWS

The Reference Committee on Articles of Incorporation and By-Laws convened its open hearing at 2 p.m. on Wednesday, April 30, to receive comments on the one item referred to it.

### SUPPLEMENTAL REPORT OF COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

The Reference Committee heard additional explanation of the reasons why the Committee on Articles of Incorporation and By-Laws recommended that the IMS By-Laws be amended to provide "staggered terms" for the three AMA alternate delegates. The Reference Committee concurs with the amendment proposed in the Supplemental Report.

The essence of the additional information is that the AMA Articles of Incorporation and By-Laws provide in part as follows:

*"Delegates and alternates from state associations, . . . shall be selected for two-year terms, and shall assume office on January 1 of the year succeeding their selection. . . . State associations entitled to more than one representative shall select them so that one-half the number, as near as may be, are selected each year."*

The above provisions have governed the "staggered terms" of IMS delegates to the AMA, as authorized by the first paragraph of Section 6, Chapter III, IMS By-Laws which provide as follows:

*Section 6. It shall elect delegates to the House of Delegates of the American Medical Association in such numbers and for such terms as the Articles of Incorporation and By-Laws of the American Medical Association may provide.*

The amendment recommended in the Supplemental Report makes an identical provision with respect to IMS alternate delegates to the AMA.

RECOMMENDATION: The Reference Committee supports the reasoning of the Committee on Articles of Incorporation and By-Laws and recommends adoption of the following implementing resolution.

*Resolved,* That Section 6 of Chapter III of the IMS By-Laws be amended by striking the following paragraph:

*"In each odd-numbered year, it shall elect three alternate delegates to the House of Delegates of the American Medical Association."*

and inserting the following in lieu thereof:

*"It shall elect alternate delegates to the House of Delegates of the American Medical Association in such numbers and for such terms as the Articles of Incorporation and By-Laws of the American Medical Association may provide."*

Mr. Speaker, I move the adoption of the foregoing resolution.

With respect to the method of determining the initial terms of the three AMA alternate delegates elected at this meeting (see lines 20-31 of the Supplemental Report of the Committee on Articles of Incorporation and By-Laws), the Chair ruled and the House of Delegates concurred at the Opening Session of the House that the method of determining which one of the elected alternate delegates would fill the initial two-year term be determined by the Board of Trustees either by lot or other method. The remaining two alternate delegates would each serve for an initial one-year term.

RECOMMENDATION: The Reference Committee proposes the following:

*Resolved,* That the foregoing action by the House of Delegates be hereby ratified and confirmed.

Mr. Speaker, I move the adoption of the foregoing resolution.

RECOMMENDATION: The Reference Committee further proposes—

*Resolved,* That the appropriate officers of the IMS be and they hereby are authorized and directed to sign, acknowledge and publish the foregoing amendment to the By-Laws and to do all other things required by law or otherwise to execute, complete and place in lawful effect such Amendment.

Mr. Speaker, I move the adoption of the foregoing Resolution.

This concludes the Report of the Reference Committee on Articles of Incorporation and By-Laws.

Respectfully submitted,
F. M. ASHLER, M.D., *Chairman*
C. D. JONS, M.D.
G. E. MICHEL, M.D.
J. S. CHAPMAN, M.D.
G. T. SCHMUNK, M.D.

## REPORTS OF OFFICERS AND MISCELLANEOUS BUSINESS

The Reference Committee on Reports of Officers and Miscellaneous Business received testimony on Wednesday, April 30, 1975 from member physicians and guests on six committee reports and four resolutions, and the following recommendations are submitted regarding the various reports and resolutions considered:

### SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES

The Board of Trustees is commended for providing its up-to-date summary of important issues confronting the medical profession, and for the diligent and effective manner in which it has conducted the business affairs of the IMS during the past year.

RECOMMENDATION: In light of the sound fiscal status of the Iowa Medical Society, the Reference Committee recommends that the following resolution be adopted:

*Resolved,* That IMS membership dues for 1976 be maintained at the present level of $200.

Mr. Speaker, I move the adoption of this resolution.

### SUPPLEMENTAL REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The Reference Committee received only positive comments about the proposal of the Committee on Medical Education and Hospitals to seek AMA approval to accredit continuing medical education programs in Iowa, specifically those of (1) hospitals which have CME activities limited to hospital staff and physicians in the local community; (2) medical organizations which do not have national scope; (3) local units of voluntary health organizations not under national administration for their continuing medical education; (4) other organizations and institutions which sponsor or promote continuing education for physicians, essentially local in nature. Under this pro-

gram, local institutions accredited by the IMS would be considered fully accredited by AMA standards, and would be included in the annual listing of AMA accredited institutions.

RECOMMENDATION: The reference committee recommends adoption of the following resolution:

*Resolved,* That the American Medical Association be requested to approve the proposed IMS Continuing Medical Education Accreditation Program, as outlined by the Committee on Medical Education and Hospitals in its 1975 Supplemental Report, and that the program be properly implemented by the IMS, through the committee.

Mr. Speaker, I move the adoption of this resolution.

### SUBCOMMITTEE ON INTERPROFESSIONAL ACTIVITIES

RECOMMENDATION: The Reference Committee recommends adoption of the following resolution:

*Resolved,* That the Iowa Medical Society approve in principle the general concept of the proposed Pilot Pharmacy Project developed and sponsored by Blue Cross and the Iowa Pharmacy Service Corporation, with the understanding that authorization be obtained from affected county medical societies prior to implementation.

Mr. Speaker, I move the adoption of this resolution.

### SUPPLEMENTAL REPORT OF SUBCOMMITTEE ON MATERNAL AND CHILD HEALTH

The reference committee reviewed the informational report of the Subcommittee on Maternal and Child Health commenting on outbreaks of measles (rubeola) in recent weeks in various parts of the state.

RECOMMENDATION: The reference committee recommends adoption of the following resolution:

*Resolved,* That the Committee on Maternal and Child Health be complimented for apprising physicians about the increasing incidence of Measles (Rubeola) and urging county medical officials to assure that adequate local effort is carried out to eradicate to the fullest extent possible all immunizable diseases.

Mr. Speaker, I move the adoption of this resolution.

### SUPPLEMENTAL REPORT OF THE COMMITTEE ON DRUG ABUSE

RECOMMENDATION: The reference committee recommends that the following resolution be adopted:

*Resolved,* That the Committee on Drug Abuse be authorized to prepare an article for publication in the JOURNAL OF THE IOWA MEDICAL SOCIETY which would present statistical and other data compiled by the University of Iowa College of Pharmacy regarding the fifteen most commonly prescribed psychotropic drugs dispensed in 100 Iowa pharmacies, and that this same information be offered for presentation at scientific meetings and other scientific endeavors of the IMS.

Mr. Speaker, I move the adoption of this resolution.

In its report to the House of Delegates, the Drug Abuse Committee also sought authority to undertake an evaluation study, at an anticipated cost of $3,000, to determine whether or not the presentation of information and statistics on the 15 psychotropic drugs identified in the survey have actually influenced the prescribing practices and patterns of physicians.

RECOMMENDATION: The committee recommends that the following resolution be adopted:

*Resolved,* That in light of anticipated costs, the proposed follow-up evaluation study be postponed.

Mr. Speaker, I move the adoption of this resolution.

### SUPPLEMENTAL REPORT OF THE COMMITTEE ON HEALTH CARE IN CORRECTIONAL INSTITUTIONS

The Committee on Health Care in Correctional Institutions is commended for its very excellent report concerning the provision of health care in city and county jails in Iowa.

RECOMMENDATION: The Reference Committee notes that the Committee on Health Care in Correctional Institutions has completed its charge, and recommends that the following resolution be adopted:

*Resolved,* That the IMS encourage the constituent county medical societies to (a) be mindful of the specialized medical care needs of local jails, and (b) confer periodically with local law enforcement officials to assure these needs are met in an appropriate manner, and be it further

*Resolved,* That the Committee on Health Care in Correctional Institutions be discharged.

Mr. Speaker, I move the adoption of this resolution.

### RESOLUTION NO 1.—INTRODUCED BY DES MOINES-LOUISA COUNTY MEDICAL SOCIETY RELATIONS WITH COLLEGE OF MEDICINE

RECOMMENDATION: The Reference Committee recommends adoption of the following substitute resolution in lieu of Resolution #1:

*Resolved,* That the University of Iowa College of Medicine continue to emphasize the importance of maintaining close communication and positive interprofessional relations between physicians at the College of Medicine, patients referred to physicians at the College of Medicine, and the referring physicians, and be it further

*Resolved,* That the College of Medicine be encouraged to develop appropriate methods to expedite the transmittal of communications to referring physicians regarding their patients, and be it further

*Resolved,* That the College of Medicine continue to encourage practicing physicians in the state to report promptly to the appropriate department at the College of Medicine any communications problems.

Mr. Speaker, I move the adoption of this substitute resolution.

*K. A. Hahn, M.D., Des Moines-Louisa Counties, offered an amendment which urged the College of Medicine to establish a continuing program to teach students, interns, residents, etc., the importance of supporting the local referring physician and avoid any untoward references. The motion to amend was defeated 68 to 62.*

### RESOLUTION NO. 4—INTRODUCED BY WEBSTER COUNTY MEDICAL SOCIETY ELECTION OF AMA PRESIDENT

"*Resolved,* That the House of Delegates of the Iowa Medical Society instruct the Iowa Delegates to the American Medical Association to propose a change in the AMA executive structure so that the President of the AMA is elected by a referendum of the entire organizational membership for a term of four years, and that the salary be commensurate with the position, so that the President can devote full time to his duties, and therefore be more effective as a national leader of our American Medical Association."

RECOMMENDATION: The Reference Committee recommends that Resolution No. 4 be *not* adopted.

*L. K. Berryhill, M.D., Webster County, moved to strike everything after the word membership in the resolution. The motion failed on a voice vote.*

Mr. Speaker, I move this resolution not be adopted.

RESOLUTION NO. 6—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY
VIEWS OF PRESIDENTIAL CANDIDATES

RECOMMENDATION: The reference committee recommends adoption of the following substitute resolution in lieu of Resolution No. 6:

*Resolved,* That candidates for elective offices of the Iowa Medical Society be invited to outline their goals and positions on various issues through statements published in bulletins disseminated to the membership prior to Annual Meetings.

Mr. Speaker, I move the adoption of this substitute resolution.

RESOLUTION NO. 8—INTRODUCED BY STUDENT IOWA MEDICAL SOCIETY
SCANLON FOUNDATION LOAN FUND

"*Resolved,* That the Iowa Medical Society take charge to substantially develop the Scanlon Medical Foundation/Iowa Medical Society Medical Student Loan Fund in order (1) that it may lessen the critical inadequacy of the medical student financial aid service, and (2) that it may hope to guarantee the needy student a source of financial sustenance, and (3) that it may contribute to a multiplicity of financial aid sources which would enable a lesser dependence upon service-linked scholarship programs, and (4) that it may again become and remain a significant factor in medical school financial aid."

RECOMMENDATION: The Reference Committee recommends the adoption of this resolution.

Mr. Speaker, I move the adoption of this resolution, as amended.

The Reference Committee wishes to compliment the Student Iowa Medical Society for presenting well-documented background information regarding its resolution.

The Reference Committee expresses appreciation to the many members who presented their views during the open committee hearings.

Respectfully submitted,
A. W. BOONE, M.D., *Chairman*
E. B. GROSSMANN, M.D.
D. M. DREES, M.D.
J. A. BROMAN, M.D.
K. D. DOLAN, M.D.

## LEGISLATION AND MEDICAL SERVICE

The Reference Committee on Legislation and Medical Service met at 2:15 p.m., Wednesday, April 30, to receive testimony on the resolutions and reports referred to it. More than 100 Iowa physicians attended this important session and many participated in the discussion. The comments and opinions were offered with conviction and sincerity, and those Society members who took part in this democratic exercise are to be commended for confronting an issue which is of perhaps unparalleled importance to the health care community and the citizens of Iowa.

Following completion of the extended hearing, the Reference Committee met in Executive Session to develop those recommendations which are contained in this report.

SUPPLEMENTAL REPORT OF THE MEDICO-LEGAL COMMITTEE
RESOLUTION NO. 3—INTRODUCED BY THE WEBSTER COUNTY MEDICAL SOCIETY
PROFESSIONAL LIABILITY

RESOLUTION NO. 7—INTRODUCED BY THE MARION COUNTY MEDICAL SOCIETY
CONTINGENCY FEE SOLUTION
RESOLUTION NO. 11—INTRODUCED BY THE BLACKHAWK COUNTY MEDICAL SOCIETY
PROFESSIONAL LIABILITY LEGISLATION

No excess verbiage needs to be employed to introduce this consideration of the current medical liability situation in Iowa. Suffice it to say, at no time in recent history, has the medical profession and the public it serves faced so grave a problem.

The situation with respect to medical liability insurance, based on specific illustrations presented at the hearing, has declined to a point where all citizens must clearly understand that without immediate improvement in the availability and cost of this essential physician commodity the prospect for attracting new and retaining existing medical manpower is extremely bleak. The consequences need no elaboration.

RECOMMENDATION: With the foregoing preamble to a complex subject, the following resolutions address themselves to the items set forth above.

*Resolved,* That the 1975 House of Delegates receive the supplemental report of the Medico-Legal Committee and, in doing so, acknowledge the tremendous contribution of time and effort given by Clarence H. Denser, Jr., M.D., chairman of the Medico-Legal Committee, and his colleagues on this committee; to Donald C. Young, M.D., chairman of the Legislative Committee, and his associates; and to the Society's legislative counsel, all for their pursuit of solutions to this dilemma.

Mr. Speaker, I move the adoption of this resolution.

*Resolved,* That the 1975 House of Delegates further acknowledge and urge continuation of the recent cooperative and constructive dialogue undertaken by Iowa Medical Society representatives with such groups as the Iowa State Bar Association, the Iowa Hospital Association, the Iowa Society of Osteopathic Physicians and Surgeons, and the Iowa Dental Association.

Mr. Speaker, I move the adoption of this resolution.

*Resolved,* That the 1975 House of Delegates express support for passage by the Iowa General Assembly of House File 803, to include the agreed upon amendments, acknowledging in doing so that much ground has been covered in a short period of time, in assembling a group of provisions which are aimed at establishing an improved medical liability climate for the State of Iowa.

Mr. Speaker, I move the adoption of this resolution.

*Resolved,* That further deliberations with representatives of the previously mentioned organizations include, but not be limited to, consideration of (1) a limitation on liability, (2) a system of binding arbitration, and (3) the manner of allocating legal and administrative costs.

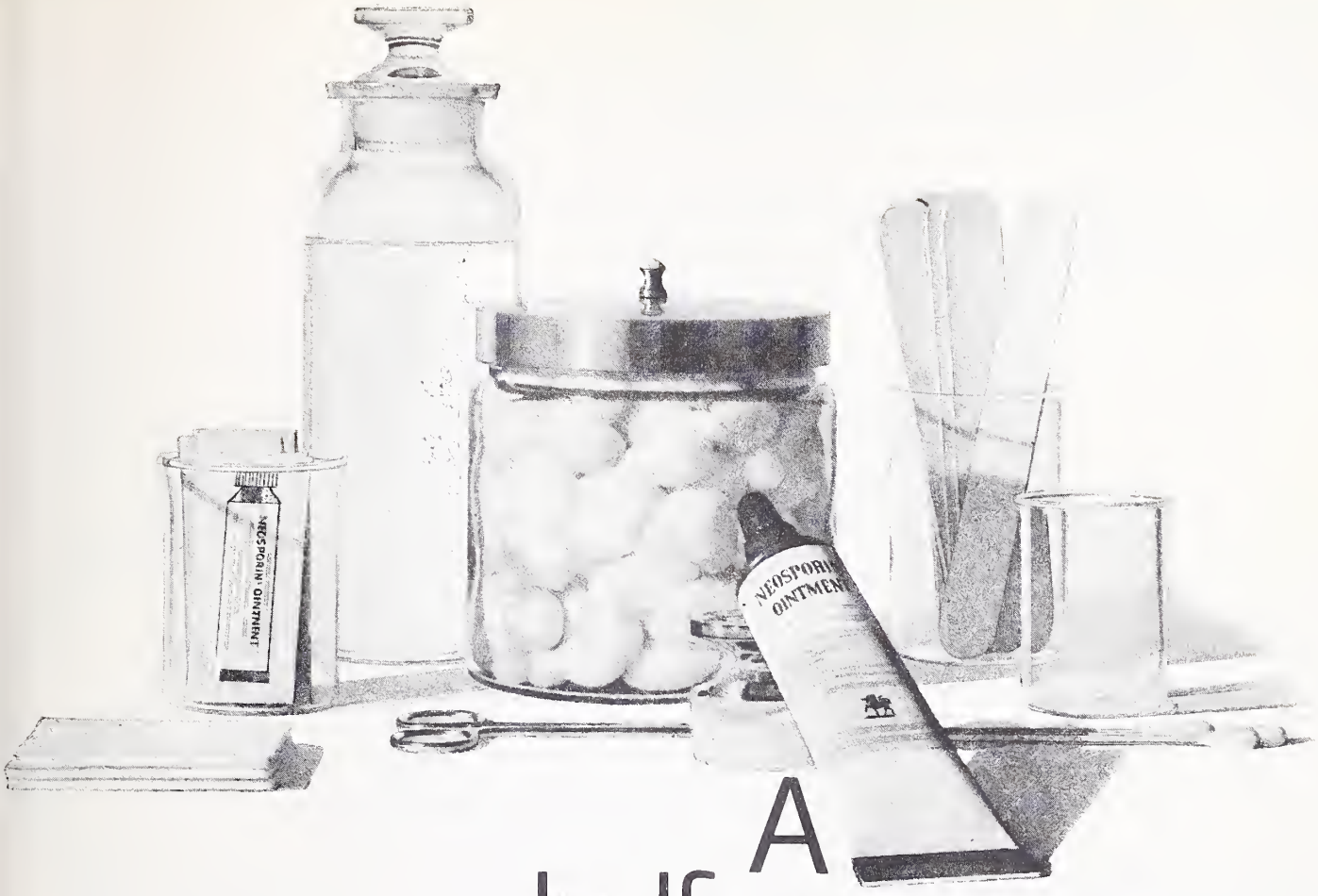
Mr. Speaker, I move adoption of this resolution.

*Resolved,* That the Iowa Medical Society involve itself cooperatively, professionally, and to the fullest extent possible, in the interim study which appears likely to be made under the aegis of the Iowa General Assembly during the balance of 1975 in pursuit of long-term solutions to this public problem.

Mr. Speaker, I move adoption of this resolution.

*Resolved,* That the Iowa Medical Society urge its members to report in documented form, providing written copies to the Iowa Medical Society and the State Insurance Commissioner, any medical liability situations where exorbitant premiums are being requested, or where instances of nonrenewal have developed.

Mr. Speaker, I move adoption of this resolution.




# A half-ounce of prevention

Use it to prevent a topical infection. Or to treat one that's already started. In either case, it's good medicine. Whether for lacerations, burns, open wounds, IV catheter or surgical aftercare. Neosporin® Ointment provides broad antibacterial coverage against common susceptible pathogens. And since it contains three antibiotics that are rarely used systemically, the risk of sensitization is reduced. Neosporin Ointment. A half-ounce of prevention. Also available in a full ounce of prevention and in convenient foil packets.

**Neosporin Ointment carried on Apollo and Skylab missions.**

## Neosporin® Ointment
## (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs.
In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

**INDICATIONS:** *Therapeutically,* used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.
*Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

**CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

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# For long-term control of hypertension*

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

**Contraindications:** Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

**Warnings:** Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

**Precautions:** Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

**Supplied:** Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

**SK&F Co., Carolina, P.R. 00630**
Subsidiary of SmithKline Corporation

# 'DYAZIDE'

## Just once or twice daily for maintenance. Hydrochlorothiazide to help keep blood pressure down and triamterene to help keep potassium levels up.

*Resolved,* That the proposal for an Iowa Medical Society group professional liability insurance program for Iowa physicians, as authorized by the Executive Council and now in process of study in cooperation with Rollins Burdick Hunter Company, of St. Louis, be pursued and that a further report be made as promptly as possible to the Executive Council and to the House of Delegates.

Mr. Speaker, I move adoption of this resolution, as amended.

*Resolved,* That the House of Delegates direct the Board of Trustees, in consultation with the Medico-Legal and Legislative Committees, to assess the situation when adjournment of the 1975 Iowa General Assembly appears imminent and determine the need for a special session of the House of Delegates to determine what direct action may be necessary to deal with the medical liability situation at that moment.

Mr. Speaker, I move adoption of this resolution, as amended.

The amendment, which was offered by J. D. Ver Steeg, M.D., Des Moines, substituted the word *when* for the words *at the time of* and added after the word *assembly* the words *appears imminent.*

### HANDBOOK REPORT—SUBCOMMITTEE ON MEDICAL REVIEW, PP. 31-32

This report sets forth the steps that have been taken since the 1974 House of Delegates action suggesting that third party customary fee data be made widely available to physicians. A special committee was appointed and evaluated the positive and negative points of the proposal. The special committee submitted recommendations to the Executive Council which forwarded the recommendations to this House of Delegates suggesting adoption.

RECOMMENDATION: *Resolved,* That Customary Fee Data not be made available to physicians upon request, but only to the Iowa Foundation for Medical Care which would continue to maintain "confidentiality" and assure "credibility."

Mr. Speaker, I move adoption of this resolution.

*Resolved,* That nonparticipating physicians be provided a copy of Blue Shield's "Explanation of Benefits" form as another mechanism for assuring the patient that his Blue Shield claim has been processed correctly.

Mr. Speaker, I move adoption of this resolution.

### RESOLUTION NO. 2—INTRODUCED BY CLINTON COUNTY MEDICAL SOCIETY PSRO OPPOSITION
### RESOLUTION NO. 9—INTRODUCED BY WRIGHT COUNTY MEDICAL SOCIETY PSRO

These resolutions were considered in light of past actions of this House of Delegates which encouraged the Iowa Foundation for Medical Care to seek designation as the PSRO for the state of Iowa. The Iowa Foundation for Medical Care has pursued PSRO designation in keeping with House of Delegates recommendations, and it appears that conditional designation may well be forthcoming within the next two weeks subject to the provisions of the law which permit physicians to object to the Iowa Foundation for Medical Care being designated as PSRO. The Reference Committee acknowledges that the American Medical Association has drafted and is seeking introduction of legislation to modify the PSRO law through approximately 22 different amendments directed toward high-quality medical care which would make it much more acceptable to physicians since most agree that outright repeal of the PSRO law does not appear to be a viable alternative. In view of the above, the Reference Committee recommends the adoption of the following substitute resolution in lieu of Resolutions 2 and 9.

RECOMMENDATION: *Resolved,* That the Iowa Medical Society and all component societies work vigorously with the Iowa congressional delegation to amend and modify the PSRO law as suggested by the AMA.

Mr. Speaker, I move adoption of this resolution.

*Resolved,* That the Iowa Foundation for Medical Care continue to actively seek designation as the PSRO organization for Iowa in keeping with past actions of the IMS House of Delegates.

Mr. Speaker, I move adoption of this resolution.

### RESOLUTION NO. 5—INTRODUCED BY DUBUQUE COUNTY MEDICAL SOCIETY ANTI-SMOKING LEGISLATION

The Reference Committee recognizes that individual choice regarding smoking and nonsmoking cannot be legislated and appreciates the differing attitudes of physicians on this subject. There was little testimony received with regard to Resolution No. 5; and the Reference Committee, therefore, submits the following recommendation.

RECOMMENDATION: *Resolved,* That Resolution No. 5 be rejected.

Mr. Speaker, I move adoption of this resolution.

### RESOLUTION NO. 10—INTRODUCED BY JASPER COUNTY MEDICAL SOCIETY PATIENT BILL OF RIGHTS

The Reference Committee acknowledges that the American Hospital Association has published a document for voluntary use by its members which is commonly referred to as the "Patient Bill of Rights." The Committee is also aware that some legislative bodies have made efforts to enact this voluntary proposal into specific statute. The medical profession historically has supported a strong and confidential doctor-patient relationship and does not feel that these principles require legislative attention since they are an inalienable part of the practice of medicine. The remarks of the Chairman of the Board to the House spoke to this very point. The Reference Committee therefore recommends adoption of the following substitute resolution in lieu of Resolution No. 10.

*Resolved,* That physicians continue to seek ways to improve communication with the patient in an honest and forthright manner to the betterment of patient care and the patient-physician relationship.

Mr. Speaker, I move adoption of this resolution.

Respectfully submitted,
J. H. LOHNES, M.D., *Chairman*
J. D. COMPTON, M.D.
G. H. WEST, M.D.
D. J. WALTER, M.D.
S. W. GREENWALD, M.D.

Dr. Caraway expressed appreciation to the delegates for their active and effective participation in the sessions of the House and in the hearings of the Reference Committees. The Speaker requested any new business to come before the House. Dr. Bliss moved the House of Delegates approve the action of the IMS Board of Trustees from the date of the last previous annual meeting. The motion, as follows, was seconded and adopted:

*Resolved,* That the action of the Board of Trustees of the Iowa Medical Society from the date of the last annual meeting be and hereby are ratified and confirmed.

Dr. Bliss acknowledged the long and dedicated service

to the medical profession of Dr. Ralph L. Wicks, and praised Dr. Wicks in particular, on behalf of the Society's officers, for his effective work during the past year as president. The House responded unanimously.

Dr. Caraway announced organizational meetings of the Board of Trustees and Judicial Council would occur immediately following adjournment of the House of Delegates and the installation of Dr. Schlaser as new IMS president. Dr. Schlaser addressed the House briefly. The House of Delegates was adjourned at 12:15 p.m.

# OFFICIAL PROCEEDINGS

## 1975 HOUSE OF DELEGATES
## SPECIAL SESSION
## JUNE 8, 1975
## DES MOINES, IOWA

(Alphabetical Index—Page 324)

The House of Delegates of the Iowa Medical Society was called into special session by the Speaker, L. D. Caraway, M.D., of Amana, at 10:05 a.m., Sunday, June 8.

The House approved the taking of attendance by signed registration cards. There were 67 delegates, 21 voting alternates and 9 ex-officio members.

| COUNTY | DELEGATE |
|---|---|
| Black Hawk | A. M. Dolan |
| | M. N. Williams |
| | R. E. Hedican, Jr. |
| | R. S. Gerard |
| | W. M. Kelly |
| | R. O. McClure* |
| | C. D. Ellyson* |
| | R. R. Roth* |
| Boone | E. E. Linder |
| Bremer | G. J. Kimball |
| Buchanan | P. J. Leehey |
| Calhoun | W. A. McCrary* |
| Carroll | J. M. Tierney |
| Cerro Gordo | G. H. West, Jr. |
| | D. D. Van Etten |
| Clay | R. L. Cox* |
| Clayton | J. D. Compton |
| Clinton | D. H. Weber* |
| Dallas-Guthrie | E. E. Lister |
| | N. L. Krueger |
| Davis | J. R. Scheibe* |
| Delaware | J. E. Tyrrell |
| Des Moines-Louisa | K. A. Hahn |
| | J. P. Stoikovic* |
| Dubuque | K. K. Hazlet |
| Fremont | F. M. Ashler |
| Greene | E. D. Thompson |
| Hardin | R. W. Schafermeyer* |
| Harrison | J. W. Barnes |
| Jasper | T. E. Kiernan |
| Jefferson | K. H. Strong* |
| Johnson | S. W. Greenwald |
| | C. E. Radcliffe |
| | R. D. Whinery |
| | N. N. Llewellyn |
| | P. M. Seebohm |
| Jones | A. P. Randolph |
| Kossuth | J. M. Rooney |
| Lee | G. C. McGinnis |
| Linn | R. A. Sautter |
| | C. R. Aschoff |
| | R. W. Conkling |
| | J. H. Lohnes |
| | J. D. Schuchmann* |
| | W. J. Robson |
| | G. R. Wessel |
| Mahaska | S. A. Smith |
| Marshall | L. O. Goodman |
| | O. D. Wolfe* |
| Monona | J. L. Garred |
| Montgomery | G. M. Skallerup |
| Muscatine | K. E. Wilcox |
| Plymouth | J. P. Trotzig |
| Pocahontas | J. M. Rhodes, Sr. |
| Polk | D. J. Walter |
| | D. C. Young |
| | M. H. Dubansky |
| | G. B. Purnell* |
| | R. C. Smith |
| | Marshall Flapan |
| | D. L. Sweem |
| | D. O. Newland |
| | Lester Beachy |
| | L. E. Longnecker |
| | R. T. Brown |
| | E. J. Laing* |
| | G. A. Kern* |
| | B. T. Woodburn* |
| | L. O. Ely* |
| Pottawattamie-Mills | A. L. Sciortino |
| | G. L. Neligh |
| | M. E. Olsen |
| | J. L. Knott |
| Poweshiek | B. G. Wiltfang* |
| Scott | J. C. Barker |
| | A. W. Boone |
| | Y. M. S. Bushan* |
| | W. B. Hofmann |
| Shelby | J. H. Spearing |
| Story | W. R. Bliss |
| Tama | A. J. Havlik |
| Wapello | L. E. Coppoc |
| Winneshiek | L. K. Lamberty |
| Woodbury | P. M. Cmeyla |
| | D. M. Youngblade |
| Wright | S. P. Leinbach* |
| Student IMS | John Wollner* |

* Alternate

LIAISON DELEGATE

J. D. Ver Steeg

EX-OFFICIO MEMBERS OF THE HOUSE

V. L. Schlaser
J. F. Bishop
J. H. Kelley
H. Rassakh
C. H. Denser, Jr.
L. D. Caraway
L. W. Swanson
R. L. Wicks
J. H. Sunderbruch

The Speaker introduced V. L. Schlaser, M.D., President of the Iowa Medical Society, for the purpose of explaining the subject to be considered in the special session.

President Schlaser reviewed the action taken by the House of Delegates on May 1, 1975. He quoted the following resolution approved at that time:

*Resolved, That the House of Delegates direct the Board of Trustees, in consultation with the Medico-Legal and Legislative Committees, to assess the situation when adjournment of the 1975 Iowa General Assembly appears imminent and determine the need for a special session of the House of Delegates to determine what direct action may be necessary to deal with the medical liability situation at that moment.*

President Schlaser advised that the Board of Trustees considered this resolution in light of legislative developments and recommended that a special session be called. Dr. Schlaser reviewed briefly the medical liability developments which have occurred in recent weeks and commended the Medico-Legal and Legislative Committees for their attention to these developments.

The Speaker indicated his plan to recess the House following the presentation of the joint report of the Medico-Legal and Legislative Committees. He explained that the Reference Committee constituted to consider the medical liability problem at the annual meeting had agreed to serve in a similar capacity at the special session. He indicated the Reference Committee would hold its open hearing at the close of the morning session of the House of Delegates.

## JOINT REPORT OF MEDICO-LEGAL AND LEGISLATIVE COMMITTEES

Presented by C. H. Denser, Jr., M.D., and D. C. Young, M.D.

(Referred to the Reference Committee on Medical Liability.)

### INTRODUCTION

The Medico-Legal and Legislative Committees met together on Wednesday, June 4, 1975 to assess the Iowa medical liability situation in preparation for this special session of the House of Delegates. The report presented at this time is submitted as a consequence of the June 4 meeting and is intended to serve two basic purposes:

1. To review developments in Iowa which pertain to the important and uncertain medical liability insurance situation, and

2. To submit certain recommendations which, if sustained by this House of Delegates, will guide the Society as we continue our effort to identify and assist in implementing solutions to a problem which bears heavily on the profession and the public.

In an effort to maximize the understanding of those physicians who are seated as delegates in the House today, we have sought to develop here a brief chronicle of Iowa medical liability history. Inasmuch as the report has been structured and approved jointly by those members of the Medico-Legal and Legislative Committees present at the June 4 meeting, we expect similarly to divide its actual presentation. I am Clarence H. Denser, Jr., M.D., Chairman of the Medico-Legal Committee, and sharing with me in making this report is Donald C. Young, M.D., Chairman of the Legislative Committee.

At the outset let me explain it is our intention at the conclusion of this formal report to request the permission of the House for additional remarks to be made by Mr. James West, legislative counsel of the Iowa Medical Society, and Mr. James Rosevear, staff director of the Task Force on Medical Liability of the American Medical Association. Mr. West will present his on-the-scene perspective of the deliberations and actions of the Iowa General Assembly. Mr. Rosevear will comment on legislative developments in selected states and summarize the activities of our medical colleagues elsewhere in the country.

### BACKGROUND

For purposes of the record, and in response to those isolated physician comments which have inferred the Iowa Medical Society has not given proper and/or adequate attention to the medical liability situation, let me submit (1) for your edification, and (2) for the record a few brief references to those activities of the Medico-Legal Committee which have occurred in the past four or five years:

1. Meetings pertaining to professional liability have been held with legal counsel and other representatives of the American Medical Association.

2. An actuarial consultant has been retained to make a limited evaluation of the Iowa medical liability insurance picture.

3. Various surveys have been conducted among the membership and other state medical societies to determine the availability and cost of liability insurance coverage, as well as to assess the claims activity.

4. Proposals have been received for Society-sponsored medical liability insurance programs from various companies including Aetna, St. Paul and Argonaut.

5. Periodic meetings have been held with local and home office representatives of the insurance carriers.

6. Dialogue has been carried on with the Insurance Commissioner and his associates, which has included attendance at rate hearings and other specially called conferences.

7. A relationship has been established with a large and reputable insurance broker for the purpose of evaluating further direct Society involvement in an insurance program.

8. An ongoing effort is being made to respond to physician concerns and inquiries; this has been done on the basis of communications with individual members, and in the form of informational presentations at regional, county and specialty meetings.

These eight summary points are not intended to be self-serving but rather they are entered into the record to illustrate the degree to which the Society has been active in this area. We have been cognizant of the ominous developments in other parts of the country. But deterioration of the situation in Iowa has occurred only within the past six to nine months. We believe the activities noted here have been appropriate and adequate in view of the Iowa circumstances. The acceleration in recent weeks has been orderly and has been undertaken with what is considered to have been good judgment.

### CURRENT LEGISLATIVE DEVELOPMENTS

We have emphasized that availability and cost of medical liability coverage began to emerge as an Iowa prob-

lem in the late summer and fall of 1974. There developed a rapid interest in finding solutions and this has intensified as the problems have increased in number and in acuteness.

With authority from the Executive Council, a Society legislative package was assembled early in 1975. The bills in this package were drawn in large measure from model legislation made available by the American Medical Association. Sponsors for the several bills in the IMS package were sought and obtained. In the process of consideration by the Commerce Committee of the House of Representatives, the bills put forward by the Iowa Medical Society were merged with the proposition to establish the Joint Underwriting Association. Out of the committee deliberation came House File 803. Modifications in House File 803 were made on the floor of the House following suggestions developed by the Health care providers and the Iowa State Bar Association.

We are extremely pleased to advise and to note for the record at this time that the Iowa House of Representatives passed House File 803 on May 23 by an 83-0 vote, and the same measure, with only slight variation, passed the Iowa Senate on June 5 by a 44-1 vote. Votes on several amendments were obviously much closer than the final tallies. But only on the section pertaining to statute of limitations was there a significant difference with the IMS position. The lawmakers clearly favored a six-year time limit over the IMS-supported four-year option.

Various attempts have been made in IMS News Bulletins and other communications to describe the contents of House File 803. It is admittedly complex and broad in subject range. There are two basic sections: the first section authorizes and sets forth procedures wherein the Insurance Commissioner may establish a Joint Underwriting Association; and the second section includes six tort system reform measures. The following brief explanations are offered in review of House File 803, hopefully to increase the understanding of the delegates:

1. **Joint Underwriting Association (JUA).** A two-year JUA is provided which requires all liability insurors in Iowa to write malpractice insurance for health providers unable to obtain insurance from private companies. Should the JUA be instituted by the Insurance Commissioner it should be understood the cost will be high and the pool of participants will be small. There is a difference between the House and Senate versions of the bill as to the manner of funding, whether in addition to the premium there will be a stabilization fund (Senate version) or an assessment (House version). It is to be hoped the additional provisions of 803 and other improved conditions may inspire the private insurance carriers to remain in the market and thus eliminate the need for the JUA.

2. **Peer Review Immunity.** Persons serving on peer review committees will not be civilly liable for their decisions under this provision. For example, if a peer review committee were to decide another doctor's work was substandard and decided to suspend his staff privileges, he may threaten a slander suit against the members of the peer review committee. The existence of this threat increases the reluctance to take action. This provision protects individual physicians as they perform peer review functions in the interest of maintaining quality medical care.

3. **Collateral Source Rule.** This section will provide that a person in a medical liability case cannot be paid twice for the same loss. If a person collects for the costs of his medical expenses from his health insurance (such as Blue Cross/Blue Shield) he may not collect those expenses also from the defendant in a malpractice suit.

4. **Written Informed Consent.** The Iowa common law provides that a physician has a duty to inform a patient generally of the nature and purpose of a proposed medical procedure together with the reasonable known risks. This is known as "informed consent." A surgeon commits a battery by performing a surgical procedure without the patient's consent. A jury question can therefore be made as to whether the patient's consent was informed, regardless of the fact that the physician was absolutely free of any negligence and the procedure was properly and skillfully performed. This section of House File 803 provides an alternative written informed consent procedure. It is not a mandatory procedure but through its use a possibly beneficial rule of evidence comes into existence.

5. **Determination of Reasonable Contingent Fee.** This section simply provides that in a medical liability case the court shall determine the reasonableness of any contingent fee arrangement. A contingent fee is subject to the approval of the judge.

6. **Statute of Limitations.** The problem of the "long tail" is one of the greatest obstacles to writing malpractice insurance. The Iowa statute is now two years from discovery of the injury. Thus, suits may develop a very long time after the provision of a medical or surgical procedure. This section provides that medical liability suits have to be brought within two years of discovery but no later than six years after the service (except for foreign objects left in the body, minors and fraudulent concealment).

7. **Elimination of Ad Damnum Clause.** Today a plaintiff in his petition demands judgment against the defendant for a stated amount of money. Seldom does the judgment bear any relationship to the demand in the petition. This section will eliminate the amount of money claimed in the petition. The plaintiff will be free to prove before the jury whatever damages he can. Through the existence of this provision the litigation-fomenting publicity will be avoided.

Final passage of House File 803 must await agreement between the House and the Senate over the several differing amendments. After this has occurred the measure must be signed into law by Governor Ray. There has to be an optimistic feeling that these steps will be taken.

It is fully realized, and it has been so stated on various occasions, that the provisions of House File 803 offer no absolute assurance that our problems will be ameliorated. We have characterized House File 803 as a short-term relief measure which will assure the availability of insurance through the JUA. More than anything, however, it must be regarded as a recognition of the problem by the Iowa General Assembly and a definite step toward a solution. We must acknowledge that a substantial legislative exercise has been completed in a relatively short time. The comments of some physicians that House File 803 does not do enough have an acknowledged basis, but they serve no useful purpose in their transmittal to members of the General Assembly. Nor will it serve any useful end to criticize the several conscientious legislators who oppose the passage. Several of these individuals have demonstrated a genuine interest in finding long-term answers, and will be active participants in the future deliberations.

From first-hand observation, including several days at the Statehouse, I can report to you we are fortunate to have made this start toward a lasting solution to the medical liability problem.

## CURRENT STATUS OF COVERAGE

The following information has been collected in the past

several days from the sources noted and is provided to give delegates an indication of the current medical liability situation in Iowa.

**State Insurance Department.** We are advised there is a market for primary coverage for almost all Iowa physicians. Coverage is most readily available at the $100,000/$300,000 primary level but can also be secured at the $200,000/$600,000 level. There have been problems experienced in obtaining coverage for (a) foreign-trained physicians, and (b) for physicians with a heavy claims experience. There continues to be a market for excess coverage in Iowa with the significant dry spots being in the specialties of neurosurgery and anesthesiology.

**Medical Protective** (Has 50.50% of the Iowa Market). After being completely out of the market from January until June (except for one or two isolated situations), Medical Protective is now receiving applications and is authorizing some new coverage. Interest in two categories of new business has been cited by their state representative: (a) new physicians joining their groups, and (b) new physicians locating in medically underserved areas. This latter category has been construed as nearly every community in Iowa. Medical Protective is writing nothing above the $200,000/$600,000 level and is expecting to reduce on renewal any existing coverage which exceeds this limit. The premium range for this coverage, effective June 1, is $443 to $2,468. The coverage remains on the occurrence form despite earlier references to a possible change.

**St. Paul** (Has 31.70% of the Iowa Market). Probably the most significant development with respect to St. Paul is the claims-made form which has reportedly been approved by the Insurance Commissioner for implementation July 1. The currently effective rates for $100,000/$300,000 coverage range from $471 to $2,979. We have been advised that St. Paul will increase primary limits only on a special arrangement basis and just for anesthesiologists. They have indicated they are authorizing excess coverage at the one million level, and the rate is determined by doubling the premium for primary coverage, e.g., umbrella for Class V is $2,979 plus $2,979 or $5,958.

The going-in or first-year rates under claims-made are significantly lower. They build gradually in three or four years to a point where presumably they are as much or more than under the present occurrence form. The claims-made premiums for $100,000/$300,000 are expected to be: Class I—$198; Class II—$321; Class III—$514; Class IV—$671 to $1,299; and Class V—$1,242 to $1,949.

**Aetna** (Has 6.40% of the Iowa Market). Aetna continues with the marketing posture it has held for the past six or so months—it is covering physicians joining its groups and is writing a limited amount of additional business. Their current rates for $100,000/$300,000 coverage range from $867 to $7,077; they subdivide Class V physicians into four categories with a range from $3,554 to $7,077. They are providing an excess market for their insureds. To obtain this, the insured is required to have $500,000/$1 million in underlying coverage; this is priced at $8,975. To take this coverage to $1.5/$2 million an additional premium of $2,095 is required for a total of $11,070.

**Professional Mutual.** This relatively small company continues to offer a market to Iowa physicians. The company reports having accepted coverage for 10 or 15 physicians in the past several months. It has been more active in the hospital area with 12 Iowa hospitals accepted in April bringing the total Iowa hospital coverage to about 20. The premiums are based on Bureau or ISO rates and the limits of liability are $300,000/$900,000. The company has no restrictions on any classification in Iowa. The area of concern among those who have expressed an interest in Professional Mutual is the requirement of an initial contribution to reserves in the amount of the first year premium. The premium range for $300,000/$900,000 coverage is $869 to $7,147.

## LONG TERM SOLUTIONS

Of nearly equal significance to House File 803, but maybe not so widely known, is Senate Joint Resolution 12, which has been approved by both legislative chambers. This resolution provides "for an interim study of the causes and effects of and solutions to the unavailability and high cost of malpractice insurance to health care providers and to provide for an appropriation."

The resolution declares the interim committee "shall prepare and submit a report to the Legislative Council and to the General Assembly at the conclusion of the interim, which shall be accompanied by legislative bill drafts designed to carry out any recommendations of the committee." A sum of $25,000 has been appropriated to accomplish the study.

Every effort will be made by the Medico-Legal and Legislative Committees to represent the Society in offering consultative services in the pursuit of this study. Our traditional tort system will undoubtedly come under scrutiny as to its ability to be responsive to our litigation-conscious society. The various concepts which have been set forth previously and which have been identified by this House of Delegates as worthy of consideration will be submitted for consideration; these include limitations on liability, varying forms of binding arbitration, the patient compensation approach, etc.

In addition to involvement in this activity to the extent possible, the Medico-Legal Committee expects to assist individual members as they experience coverage problems. We also expect to continue our negotiations with Rollins, Burdick, Hunter, Inc., as instructed by the House of Delegates, in the consideration of direct involvement by the IMS in a coverage program for member physicians.

## RECOMMENDATIONS

The following recommendations are submitted to this House of Delegates for consideration at this special session:

1. That the efforts of the Iowa General Assembly in the first session of the 67th biennium be acknowledged with gratitude as they pertain to the subject of medical liability.

2. That the Iowa General Assembly be encouraged to maximize its efforts during the interim in pursuit of a more long-term solution to the medical liability dilemma, doing so in the knowledge that the Iowa Medical Society stands ready and willing to extend its cooperation and expertise to the fullest extent possible.

3. That the Iowa Medical Society discourage and disassociate itself from any moratorium or work stoppage undertaken to demonstrate dissatisfaction with the conditions as they exist at this time, fully recognizing that individual member physicians may elect to withhold non-emergency services if confronted by unrealistic premium costs.

4. That the Iowa Medical Society do all things possible to obtain acceptable medical liability insurance coverage for its member physicians and to call upon the State Insurance Commissioner to continue to be supportive in this regard.

5. That the Iowa Medical Society reaffirm its belief in the peer review system and do all things necessary to assure that quality medical care is delivered by its member physicians.

6. That the Iowa Medical Society urge all parties and agencies involved, e.g., the insurance carriers, the State Insurance Department, the legal profession, and the medical profession, to support the development, retrieval and compilation of realistic and meaningful data on which to base remedial programs.

7. That the Iowa Medical Society support thorough investigation of (a) a limitation on liability with constitutional safeguards, and (b) the broad concepts of binding arbitration and patient compensation.

8. That the Iowa Medical Society be mindful of the varying forms of coverage which are emerging, i.e., occurrence, claims-made, etc., and make every effort to foster those arrangements which (a) assure the availability of coverage, (b) do not unjustly threaten the economics of the physician, and (c) uphold the rights and interests of the public.

As stated at the outset of this report, Mr. Speaker, we would like to call on Mr. West and Mr. Rosevear to amplify briefly on the content of this report. Thank you.

Following the presentation of the joint report of the Medico-Legal and Legislative Committees, permission was requested of the House to allow Mr. James West, the Society's legislative counsel, and Mr. James Rosevear, Staff Director, Task Force on Medical Liability, American Medical Association, to present informal comments. Mr. West discussed the developments which have occurred in recent weeks leading up to the passage in both the House and Senate of House File 803. Mr. Rosevear described legislative developments in various other states and advised that Iowa ranks near the top in terms of tort reform legislation passed. He complimented the Society on its effective efforts to initiate remedial action in this critical area.

The Speaker recessed the House at approximately 11:10 a.m. and urged participation in the hearing of the Reference Committee.

* * *

The Speaker called the afternoon session of the House of Delegates to order at approximately 3:15 p.m. He requested the presentation of the report of the Reference Committee on Medical Liability.

## REFERENCE COMMITTEE ON MEDICAL LIABILITY

The Reference Committee on Medical Liability met at 11:20 a.m. Sunday, June 8, 1975, to hear comments of those delegates and member physicians in attendance at this special session of the House of Delegates devoted specifically and entirely to professional liability. The open discussion consumed approximately two hours and included references to numerous aspects of the complex problem.

The Reference Committee expressed particular agreement that the quotations offered during the course of the hearing do have real meaning for the House of Delegates and the IMS members in total:

*"Every man has a right to his opinion, but no man has a right to be wrong in his facts."*

BERNARD BARUCH

*"The degree of one's emotion varies inversely with one's knowledge of the facts—the less you know, the hotter you get."*

BERTRAND RUSSELL

Following the conclusion of the open hearing, the Reference Committee met in Executive Session to develop those recommendations which appear in the balance of this report. It should be stated at the outset that the limitations of time make difficult the development of reports which contain highly detailed or specific information.

## JOINT REPORT OF MEDICO-LEGAL AND LEGISLATIVE COMMITTEES

The following resolutions are for the consideration of the House of Delegates in response to the report which has been submitted jointly by the Medico-Legal and Legislative Committees:

*Resolved,* That this House of Delegates reiterate its previous affirmation of the conscientious and productive efforts of the leadership of the Iowa Medical Society, and in doing so single out particularly the work of the Medico-Legal Committee, the Legislative Committee and Mr. James West, the Society's legislative counsel.

Mr. Speaker, I move the adoption of this resolution.

*Resolved,* That the passage of House File 803 by the Iowa General Assembly be acknowledged as a productive project, and in acknowledgment of this development, the Iowa Medical Society find appropriate opportunity to express appreciation for this initial step in the pathway to a permanent solution.

Mr. Speaker, I move the adoption of this resolution.

*Resolved,* That the Iowa General Assembly be urged to proceed in the interim to pursue a more definitive solution to the medical liability problem. In offering this Resolution, the Iowa Medical Society assure the legislative assembly of its willingness to provide its manpower and expertise in the coming months as a detailed report, including legislative recommendations, is developed for presentation to the Iowa General Assembly in 1976.

Mr. Speaker, I move the adoption of this resolution.

*Resolved,* That the Iowa Medical Society continue to do all things possible in collaboration with the State Insurance Commissioner to obtain acceptable medical liability insurance coverage for member physicians.

Mr. Speaker, I move adoption of this resolution.

*Resolved,* That the Iowa Medical Society reaffirm the profession's full support of and belief in the delivery of high quality medical care and urge that maximum effort be exerted through peer review mechanisms to assure that such care is provided by the medical profession of this state.

Mr. Speaker, I move the adoption of this resolution.

*Resolved,* That the Iowa Medical Society, through the Committee on Legislation and the Medico-Legal Committee:

(1) Develop an on-going fact-finding program to include surveying of the IMS membership on a periodic basis, undertaking this type of activity following consultation with appropriate individuals and agencies, including the State Insurance Commissioner, to support the development, retrieval and compilation of realistic and meaningful data on which to base remedial programs.

(2) Structure and implement an effective education program pertaining to all aspects of professional liability for the enlightenment of the profession, the legislators and the people of Iowa.

(3) Continue the study of the various forms of coverage available and emerging, i.e., occurrence, claims-made, and in this connection file with the Insurance Commissioner a request to delay implementation of the claims-made form in Iowa until completion of the interim legislative study.

(4) Pursue the thorough investigation of those long-term approaches which have been previously enunciated and which serve to modify this unique form of liability, to include but not be limited to a limit of liability, the

concept of a patient's compensation program and binding arbitration.

Mr. Speaker, I move the adoption of this resolution.

*Resolved,* That the Board of Trustees be instructed to assess the fiscal impact of the foregoing resolutions and be authorized, if necessary, to levy a special assessment not to exceed $100 per active member to fund this activity.

Mr. Speaker, I move the adoption of this resolution.

J. H. LOHNES, M.D., *Chairman*
J. D. COMPTON, M.D.
G. H. WEST, M.D.
D. J. WALTER, M.D.
S. W. GREENWALD, M.D.

The Speaker complimented the reference committee and the entire House of Delegates for the attention given to the problem of medical liability. He urged the delegates to report the highlights of the meeting to their constituent physicians. He adjourned the meeting at approximately 4:25 p.m.

# IOWA MEDICAL SOCIETY
# Officers and Committees, 1975-1976

President ..... Verne L. Schlaser, Des Moines
President-Elect ..... James F. Bishop, Davenport
Vice President ..... Craig D. Ellyson, Waterloo
Secretary ..... W. R. Bliss, Ames
Treasurer ..... T. A. Burcham, Des Moines
Speaker of the House of Delegates ..... L. D. Caraway, Amana
Vice Speaker of the House of Delegates
..... R. D. Whinery, Iowa City

### COUNCILORS

| | *Term Expires* |
|---|---|
| First District, Clarkson L. Kelley, Jr., Charles City | 1976 |
| Second District, W. V. Wulfekuhler, Mason City | 1977 |
| Third District, Donald F. Rodawig, Jr., Spirit Lake | 1978 |
| Fourth District, D. M. Youngblade, Sioux City | 1976 |
| Fifth District, Clarence H. Denser, Jr., Des Moines | 1978 |
| Sixth District, A. M. Dolan, Waterloo | 1976 |
| Seventh District, John E. Tyrrell, Manchester, Chairman | 1977 |
| Eighth District, R. L. Kent, Fort Madison | 1977 |
| Ninth District, S. A. Smith, Oskaloosa | 1977 |
| Tenth District, James D. Kimball, Osceola | 1978 |
| Eleventh District, Arthur L. Sciortino, Council Bluffs | 1976 |
| Twelfth District, E. E. Linder, Ogden | 1977 |

### TRUSTEES

| | |
|---|---|
| A. J. Havlik, Tama, Chairman | 1976 |
| J. H. Kelley, Des Moines | 1977 |
| Hormoz Rassekh, Council Bluffs | 1978 |

### DELEGATES TO AMA

| | |
|---|---|
| Leslie W. Swanson, Mason City | December 31, 1976 |
| Christian E. Radcliffe, Iowa City | December 31, 1977 |
| Erling Larson, Jr., Davenport | December 31, 1976 |

### ALTERNATE DELEGATES TO AMA

| | |
|---|---|
| John R. Anderson, Boone | December 31, 1976 |
| John M. Rhodes, Sr., Pocahontas | December 31, 1977 |
| John R. Scheibe, Bloomfield | December 31, 1976 |

### EXECUTIVE COUNCIL

V. L. Schlaser ..... Des Moines
J. F. Bishop ..... Davenport
Craig D. Ellyson ..... Waterloo
W. R. Bliss ..... Ames
T. A. Burcham ..... Des Moines
A. J. Havlik ..... Tama
J. H. Kelley ..... Des Moines
Hormoz Rassekh ..... Council Bluffs
C. L. Kelly, Jr. ..... Charles City
W. V. Wulfekuhler ..... Mason City
D. F. Rodawig, Jr ..... Spirit Lake
D. M. Youngblade ..... Sioux City
C. H. Denser, Jr. ..... Des Moines
A. M. Dolan ..... Waterloo
J. E. Tyrrell ..... Manchester
R. L. Kent ..... Fort Madison
S. A. Smith ..... Oskaloosa
J. D. Kimball ..... Osceola
Arthur L. Sciortino ..... Council Bluffs
E. E. Linder ..... Ogden
L. D. Caraway ..... Amana
L. W. Swanson ..... Mason City
C. E. Radcliffe ..... Iowa City
Erling Larson, Jr. ..... Davenport
J. M. Rhodes, Sr. (non-voting) ..... Pocahontas
J. R. Anderson (non-voting) ..... Boone
J. R. Scheibe (non-voting) ..... Bloomfield
Ralph L. Wicks ..... Boone
C. W. Seibert ..... Waterloo
J. D. Ver Steeg ..... Des Moines

### THE JOURNAL

M. E. Alberts ..... Des Moines

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### COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS

K. J. Judiesch, Chairman ..... Iowa City
J. F. Bishop ..... Davenport
R. J. Dawson ..... Estherville
T. M. Gary ..... Cherokee
P. J. Leehey ..... Independence
H. J. Smith ..... Des Moines

### BLUE SHIELD LIAISON COMMITTEE (TERMS EXPIRE JULY 1975)

E. E. Linder ..... Ogden
C. E. Radcliffe ..... Iowa City
V. L. Schlaser ..... Des Moines
A. J. Havlik ..... Tama
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# INDEX


Acupunture, 293
Ad damnum clause, 276, 280, 304, 318
Aetna Insurance Company, 319
Aging and Chronic Illness, Subcommittee on, 283
Alcoholism, Committee on, 286
Alcoholism law, 284, 286
Allied health professions, relations with, 296
Alternate Delivery Systems, Committee on, 286
AMA alternate delegates, selection of, 303, 312
AMA/CPT, 279, 300
AMA, CME accreditation program, 312-313
AMA continuing medical accreditation, 277
AMA-ERF, 294
AMA Judicial Council, 274
AMA, national health insurance proposal, 275
AMA, national legislative involvement, 276
AMA president, election of, Webster County Medical Society resolution, 308, 313
AMA, professional liability counsel, 317
Arbitration, system of binding, 314, 320
Architectural Education, Committee on, 286
Articles of Incorporation and By-Laws, Reference Committee Report, 312
Articles of Incorporation and By-Laws, report of Standing Committee, 274
Articles of Incorporation and By-Laws, Supplemental Report of Standing Committee, 303, 312
Assessment, authority to make, 321
Associate memberships, 310
Auxiliary, immunization activity, 284

Black Hawk County Medical Society resolution, professional liability legislation, 310, 314
Blood Banking, Committee on, 286-287
Blue Cross/Blue Shield, alternate delivery system, 286
Blue Cross/Blue Shield, IMS group program, 289
Blue Cross/Blue Shield, pilot pharmacy project, 281-282
Blue Shield, coverage for mental diseases, 284
Blue Shield customary fee data, 279
Blue Shield, EOB form to non-participating physicians, 315
Blue Shield, PADE program, 300
Blue Shield, report of IMS House, 299ff
Blue Shield, UCR guidelines, 278
Board of Health, physician members, 283
Board of Medical Examiners, 276, 277, 295, 296
Board of Trustees, 271, 274
Board of Trustees, Supplemental report of, 295ff, 312
Brain death, definition of, 292

Cancer, detection program, 292
Certificate of need legislation, 276
Chiropractic, 293
Civil commitment law, 284
Clinton County Medical Society resolution, PSRO Opposition, 308, 315
Collateral source rule, 276, 280, 304, 318
College of Medicine, cancer control program, 292
College of Medicine, family practice residency, 288
College of Medicine, organ transplant program, 292
College of Medicine, relations with, Des Moines-Louisa Counties Medical Society resolution, 307-308, 313
College of Medicine, student preceptor activity, 293
Commitment, law on, 284
Communicable disease eradication, 283-284
Communications, IMS to physicians, 272
Community Emergency Medical Services, Committee on, 287
Comprehensive Health Planning, 287-288
Contingency fees, 276, 280, 304, 318
Contingency fee solution, Marion County Medical Society resolution, 309, 314
Continuing medical education, 276, 277-278, 295-296, 312-313
Correctional institutions, health care in, 306-307, 313
Councilors, 274
County society officers, 256
Current Procedural Terminology, 300
Customary fee data, 279, 315

Delegates, IMS alternate to AMA, 303, 312
Delegates, listing of, 269, 311, 316, 317
Delegation of Authority, Committee on, 287
Delivery of Health Services, Committee on, 287-288
Des Moines-Louisa, Counties Medical Society Resolution, Relations with College of Medicine, 307-308, 313
Drug Abuse, Committee on, 288-289
Drug Abuse, Supplemental Report of Committee on, 306, 313
Drugs, Maximum Allowable Cost Plan, 276
Dubuque County Medical Society resolution, Anti-smoking legislation, 309, 315
Dubuque County Medical Society, resolution, views of presidential candidates, 309, 314
Dues, 297, 312

Emergency medical services, 287, 292
Ethics, 274
Executive Council, 271
Eye Care Committee, 289

Family Nurse Practitioner program, 287, 292
Family Practice Residency program, 276
Field service, 272
Fifty Year Club, 253
Finances, IMS, 273, 274, 296-297

Grievance Committee, 275
Group Insurance, Committee on, 289

Hawkeye Science Fair, 281
Health Care in Correctional Institutions, Committee on, 289-290
Health Care in Correctional Institutions, Supplemental Report of Committee on, 306-307, 313
Health Education, Committee on, 275
Health Facilities Association of Iowa, 280
Health insurance, IMS group program, 289
Health maintenance organizations, 278, 286
Health manpower, legislation, 276
Health planning, 275-276, 287, 295
Health Planning and Resources Development Act, 287-288
Health services areas, 287-288
Health, State Department of, 279, 283-284, 305
Historical Committee, 290
Hospital-medical staff relations, 296

Immunization, 283-284, 305, 313
IMS, to accredit CME programs, 277
IMS, CME accreditation program, 296, 312, 313
IMS representation, national level, 271
Independent Laboratories, Committee on, 291
Industrial Health, Committee on, 291
Informed consent, 280, 318
Insurance Commissioner, 280, 304-305, 317
Insurance, group programs, 289
Intermediate Care Facilities Program, 280, 283, 285
Interprofessional Activities, Subcommittee on, 281-282, 313
Iowa Blood Council, 287
Iowa consumer credit code, 274
Iowa Foundation for Medical Care, 278-279, 284, 286, 297, 315
Iowa Health Council, 282-283, 296
Iowa Hospital Association, 285, 286, 293, 296
Iowa Nurses' Association, 287
Iowa Pharmaceutical Association, 281-282, 296, 306
Iowa Physician's Assistant Society, 282, 292
Iowa Physical Therapy Association, 285, 293, 296
Iowa State Board of Nursing, 287

Jails, health care in, 306-307, 313
Jasper County Medical Society resolution, Patient Bill of Rights, 309, 315
Joint Underwriting Association, 304, 318
Journal of the Iowa Medical Society, 272, 285
Judicial Council, 271, 274

Laboratory evaluation programs, 291
Leadership, IMS regional conferences, 296
Legislation, 304, 314-315, 318, 319
Legislation, Committee on, 275
Legislative contact men, 277
Legislative and Medico-Legal Committees, joint report to special session, 317ff
Liability of health care providers, 276
Life memberships, 310
Limitation of liability, 314

Malpractice, 276, 280, 295, 303-304, 309, 310, 314, 317ff, 320-321
Manpower, legislation, 276
Marion County Medical Society resolution, contingency fee solution, 309, 314
Maternal and Child Health, Subcommittee on, 283-284
Maternal and Child Health, Supplemental Report of Subcommittee on, 305, 313
Maternal Mortality Committee, 284
Maximum Allowable Cost Drug Plan, 276
MD-DO Liaison Committee, 291
Measles immunization, 305, 313
MECO Program, 293
Medicaid, 279-280, 283, 284-285, 299
Medical Assistants Advisory Committee, 291
Medical Education and Hospitals, Committee on, 277
Medical Education and Hospitals, Supplemental report of Committee on, 312-313
Medical Examiners, Board of, 277, 282, 295-296
Medical Practice in Health Facilities and Homes, Subcommittee on, 279-280
Medical liability, 276, 280, 295, 303-304, 309, 310, 314, 317ff, 320-321
Medical Liability, Reference Committee Report to Special Session, 320-321
Medical Protective Insurance Company, 319
Medical Review, Handbook Report of Subcommittee on, 315
Medical Review, Subcommittee on, 278
Medical Service, Committee on, 278
Medicare, 299
Medicare, clinical laboratory qualifications, 291
Medicine and Religion, Committee on, 291-292
Medico-Legal Committee, 280
Medico-Legal and Legislative Committees, joint report to special session, 317ff
Medico-Legal Committee, Supplemental Report, 303-304, 314-315
Membership, 272-273
Mental illness, 284
Model regional primary health care center, 288, 293

National Emergency Medical Service, Committee on, 292
National health insurance, 275, 278
National Health Planning and Resources Development Act, 275-276
Necrology Committee, 275
Necrology Committee, Supplement Report, 302
Nominating Committee, 302
Nursing homes, 279-280
Nursing, liaison with, 287, 296

Obesity, surgical treatment for, 278-279
Oncology, Committee on, 292
Optometry, 289
Organ Transplantation, Committee on, 292
Osteopathic liaison, 291
Over-due accounts, service charge for, 274

Paramedical Service, Committee on, 292-293
Patient bill of rights, Jasper County Medical Society resolution, 309, 315
Peer review, 278, 280
Peer review immunity, 276, 304, 318
Pharmacy, Maximum Allowable Drug Plan, 276
Pharmacy pilot project, 281-282, 313
Physical therapy, 293, 296
Physician's assistants, 288
Physician's assistants, drug prescribing, 282
Physician/Pharmacist Code of Understanding, 296
Physician-pharmacist relations, 274
Preceptorship Committee, 293
Prescribing practices, 288, 306, 313
Presidential candidates, views of, Dubuque County Medical Society resolution, 309, 314
Professional liability, 276, 280, 295, 303-304, 309, 310, 314, 317ff, 320-321
Professional liability legislation, Black Hawk County Medical Society resolution, 310, 314
Professional liability, Webster County Medical Society resolution, 308, 314
Professional Mutual Insurance Company, 319

Professional standards review organizations, 276, 278, 297-298
Proof of alleged negligence, 276
Prouty Company, 289
PSRO Opposition, Clinton County Medical Society resolution, 308, 315
PSRO, Wright County Medical Society resolution, 309, 315
Psychiatric Care, Subcommittee on, 284
Public Assistance, Subcommittee on, 284-285
Public Relations, Committee on, 280-281
Public Safety, State Department of, 285
Publications Committee, 285

Quackery, Committee on, 293

Radio programming on health, 275
Radiology control, 276
Rehabilitation, Subcommittee on, 285
Reports of Officers, Handbook, 271
Reports of Officers and Miscellaneous Business, Reference Committee Report, 312ff
Rollins Burdick Hunter Company, 280, 304, 315, 319
Rural Health, Committee on, 293

Safe Transportation, Committee on, 285
Scanlon Foundation Loan Fund, Student Iowa Medical Society resolution, 309, 314
Scanlon Medical Foundation/Iowa Medical Society, 301-302
Scientific Program, 271, 283, 295
Scientific Work, Committee on, 283
Sedlacek Foundation for Alcoholism, 286
Service charge, over-due accounts, 274
Smoking, legislation against, Dubuque County Medical Society resolution, 309, 315
Social Services, State Department of, 279, 282-283, 285
Specialty listing, 278
Sports Medicine, Committee on, 293-294
St. Paul Insurance Company, 319
Standing committees, reports of, 274
State Comprehensive Health Plan, 288
State Departments, Committee on, 283
Statewide Physicians Group Health Program, 289
Statute of limitations, 276, 280, 304, 318
Student Iowa Medical Society, 274
Student Iowa Medical Society resolution, Scanlon Foundation Loan Fund, 309, 314
Supplemental Security Income program, 284-285

Telephone listings for physicians, 274
Television programming on health, 275
Treasurer, Report of, 273-274

UCR, 299
UCR, customary fee data, 279
UCR guidelines, 278
Usual, Customary and Reasonable, IMS-BS guidelines, 278

Voluntary Health Agencies, Committee on, 294

Webster County Medical Society resolution, election of AMA president, 308, 313
Webster County Medical Society resolution, professional liability, 308, 314
Woman's Auxiliary Advisory Committee, 294-295
Workmen's Compensation, IMS insurance program, 289
Wright County Medical Society resolution, PRSO, 309, 315

# Morbidity Report for May, 1975

| Disease | May 1975 | 1975 to Date | 1974 to Date | Most May Cases Reported From These Counties |
|---|---|---|---|---|
| Amebiasis | 6 | 10 | 8 | Boone, Jefferson, Polk, Winnebago |
| Ascariasis | 1 | 7 | 5 | Johnson |
| Brucellosis | 2 | 11 | 7 | Dubuque, Woodbury |
| Chickenpox | 1282 | 6420 | 5660 | Dubuque, Linn, Madison, Polk, Sac |
| Conjunctivitis | 207 | 798 | 469 | Benton, Johnson, Linn, Marion, Marshall |
| Encephalitis due to herpes | 1 | 4 | | Lucas |
| Erythema infectiosum | 35 | 132 | 456 | Buena Vista, Clayton, Dubuque, Jackson |
| Gastrointestinal viral inf. | 1578 | 14563 | 5344 | Bremer, Chickasaw, Floyd, Humboldt |
| Giardiasis | 3 | 7 | 14 | Johnson, Webster, Winnebago |
| Guillian-Barré syndrome | 2 | 5 | 4 | Johnson, Tama |
| Hepatitis, A (infectious) | 17 | 83 | 153 | Johnson, Linn, Polk |
| Hepatitis, B (serum) | 13 | 44 | 41 | Dubuque, Polk |
| Hepatitis, type unspecified | 7 | 18 | 15 | Scattered |
| Impetigo | 62 | 320 | 188 | Linn, Marshall, Muscatine, Sac |
| Infectious mononucleosis | 154 | 751 | 527 | Bremer, Johnson, Linn, Polk |
| Influenza, lab confirmed | 4 | 159 | 116 | Johnson, Linn, Polk |
| Influenza-like illness | 1528 | 35974 | 89193 | Bremer, Linn, Madison, Polk, Story |
| Meningitis Bacterial | 1 | 6 | | Winneshiek |
| *H. Influenza* | 3 | 7 | | Benton, Butler, Muscatine |
| Type unspecified | 3 | 21 | 15 | Johnson, Pottawattamie, Scott |
| Mumps | 320 | 912 | 1557 | Monroe, Muscatine, Polk, Wapello |
| Pediculosis | 41 | 190 | 228 | Louisa, Palo Alto |
| Pinworms | 8 | 23 | | Delaware, Johnson, Linn, Polk, Worth |
| Pneumonia | 108 | 621 | 503 | Scattered |
| Rabies in animals | 12 | 41 | 56 | Scattered |
| Rheumatic fever | 2 | 9 | 41 | Sac |
| Ringworm, body | 43 | 169 | 95 | Scattered |
| Ringworm, scalp | 1 | 7 | | Winneshiek |
| Rocky Mountain Spotted Fever | 2 | 2 | | Boone |
| Rubella | 10 | 18 | 14 | Polk, Winneshiek |
| Rubeola | 116 | 404 | 28 | Polk, Warren |
| Salmonellosis | 17 | 71 | 59 | Dubuque, Johnson, Linn, Pottawattamie |
| Scabies | 37 | 225 | 45 | Dubuque, Linn, Polk, Pottawattamie |
| Shigellosis | 5 | 31 | 64 | Dubuque, Harrison, Polk, Scott |
| Streptococcal infections | 1162 | 6074 | 6077 | Jackson, Johnson, Polk, Washington |
| Tuberculosis, total ill | 19 | 58 | | Scattered |
| Tubercuolsis, bact. positive | 8 | 26 | | Scattered |
| Veneral diseases: Gonorrhea | 557 | 2574 | 2557 | Black Hawk, Linn, Polk, Scott, Woodbury |
| Syphilis | 29 | 130 | 179 | Cerro Gordo, Linn, Polk, Pottawattamie |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | | | |
|---|---|---|---|---|---|
| Coxsackie B4 | 1 | Cytomegalovirus | 1 | Herpes zoster | 6 |
| Coxsackie B5 | 1 | Herpes simplex | 14 | Adenovirus | 1 |

# LIST YOUR WANTS

No charge is made for the ads of members, wives of deceased members of the Iowa Medical Society or physicians seeking Iowa locations; for others the cost is $1.00 per line, $5.00 minimum per insertion. Copy for ad must be received by the seventh of the month for the following issue. Send to JOURNAL OF THE IOWA MEDICAL SOCIETY, 1001 Grand, West Des Moines 50265.

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**GENERAL PRACTITIONER NEEDED:** Friendly rural community. Moville, Iowa, population 1,200, 14 miles east of Sioux City, Iowa. Unlimited opportunity for a family physician. Phone 712/873-3158 or 712/873-3455.

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**PHYSICIANS FOR STUDENT HEALTH SERVICE—Attractive small midwest town with excellent University of 20,000 students. New performing center attracts nationally prominent performing artists. Salary negotiable. Excellent fringe benefits. Contact Loren L. Augustyn, M.D., Student Health Service, Iowa State University, Ames, Iowa 50010. Telephone 515/294-5801.**

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**FAMILY PRACTITIONER wanted to take over established practice with four Family Physicians in 16-man multispecialty group. Central Iowa community of 30,000. Competitive financial arrangements, many benefits, 250-bed regional hospital. Write No. 1509, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.**

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**FOR SALE—Large solo practice and elegantly equipped 11-room clinic, suitable for multiple practice. Retiring. Very reasonable. Ross King, M.D., Clinton Medical Clinic, Clinton, Iowa 52732. Telephone—319/242-7576 or 319/242-7522.**

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**IMMEDIATE OPENING for Family Practice, General Physician, with Iowa license or qualifications for Iowa license. Very busy urban practice with three men, one of whom leaving for Emergency Room work July 1, 1975. Salary $24,000 and up depending on training and qualifications. Benefits of professional corporation available after one year. Two open staff hospitals where privileges depend on training and qualifications. Write, call or visit—Physicians of Family Medicine, P.C., 811 5th Avenue S.E., Cedar Rapids, Iowa 52403. 319/365-8618.**

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---

**NEUROSURGEON AND NEUROLOGIST—Attractive opportunity to join 33 physician multispecialty group just completed new building program near hospital. Very top starting salary and fringe benefits, professional liability coverage, partnership after one year, and incentive plan profit formula. Numerous boating and other recreational activities, clean air, 65M population in city located on the Mississippi. Contact: Robert T. Melgaard, M.D., Executive Director, or Eugene V. Conklin, M.D., Recruitment Chairman, Medical Associates, Dubuque, Iowa—319 557-6250 or 557-6321.**

---

**ORTHOPEDIC SURGEON—Attractive opportunity to join two physician department of Orthopedics, 33 physician multispecialty, just completed new building program near hospital, very top starting salary and fringe benefits, professional libality coverage, partnership after one year, and incentive profit formula. Numerous boating and other recreational activities, clean air, 65M population in city located on the Mississippi. Contact: Robert T. Melgaard, M.D., Executive Director, or Eugene V. Conklin, M.D., Recruitment Chairman—319 557-6250 or 319 557-6321.**

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**ACUTE ILLNESS PHYSICIAN—to also work in Industrial Medicine and Emergency Area—33 physician multispecialty group, just completed new building program, regular hours, no night work. Numerous boating and other recreational activities, clean air, 65M population in city located on the Mississippi. Contact: Robert T. Melgaard, M.D., Executive Director, or Eugene V. Conklin, M.D., Recruitment Chairman, Medical Associates, Dubuque, Iowa—319 557-6250 or 557-6321.**

## INDEX TO ADVERTISERS


Burrough Wellcome Co. ..... 314A

Flint Laboratories ..... 306A, B

Lilly, Eli, & Co. ..... 249

Medical Protective Company ..... 270

Michigan Department of Mental Health ..... 272

Pharmaceutical Manufacturers Association ..... 266-267

Prouty Company ..... 290

Roche Laboratories ..... 250-251, 290B, C, 331-332

Roerig, J. B., & Co. ..... 290D

Searle, G. D., & Co. ..... 290, 290A

Smith, Kline and French Laboratories ..... 314B

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• **Q & A On Claims-Made**—Page 339
• **Liability Update**—Page 348
• **Wilson's Disease**—Page 349

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# Both often

Predominant psychoneurotic anxiety

Associated depressive symptoms

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in freque y and/or severity of grand mal seizures r y require increased dosage of standard a i- convulsant medication; abrupt withdra l may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous i gestion of alcohol and other CNS depre sants. Withdrawal symptoms (similar t those with barbiturates and alcohol) ha occurred following abrupt discontinuar e (convulsions, tremor, abdominal and m s- cle cramps, vomiting and sweating). K addiction-prone individuals under care

# respond to one

According to her major
mptoms, she is a psychoneu-
tic patient with severe
xiety. But according to the
scription she gives of her
elings, part of the problem
ay sound like depression.
his is because her problem,
though primarily one of ex-
ssive anxiety, is often accom-
nied by depressive symptom-
ology. Valium (diazepam)
n provide relief for both—as
e excessive anxiety is re-
ved, the depressive symp-
ms associated with it are also
ten relieved.

There are other advan-
ges in using Valium for the
anagement of psychoneu-
tic anxiety with secondary
pressive symptoms: the
ychotherapeutic effect of
alium is pronounced and
pid. This means that im-
ovement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

# Valium® (diazepam)

## 2-mg, 5-mg, 10-mg tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

rveillance because of their predisposi-
n to habituation and dependence. In
egnancy, lactation or women of child-
aring age, weigh potential benefit
ainst possible hazard.

**ecautions:** If combined with other psy-
otropics or anticonvulsants, consider
refully pharmacology of agents em-
oyed; drugs such as phenothiazines,
rcotics, barbiturates, MAO inhibitors
d other antidepressants may potentiate
action. Usual precautions indicated in
tients severely depressed, or with latent
pression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

# President's Page

On June 30, Governor Ray signed House File 803 into law. This key development represents a first step toward a solution of the medical liability problem. We must now involve ourselves cooperatively in the Legislative Interim Study.

We continue to plead for specific and meaningful information from member physicians to help us substantiate the magnitude of the liability problem. We need the precise figures on any exorbitant premiums (with previous premium amounts for comparison use). We need data on changes in coverage limits as well as reports pertaining to the unavailability of primary or excess coverage. We need copies of correspondence where insurance companies have elected to non-renew coverage. This kind of information will be of the utmost value to the Medico-Legal and Legislative Committees as they work with the legislators, the Insurance Commissioner and the insurance companies. Don't expect someone else to provide this information—do it yourself.

Also, this month, HEW, through Crossley Surveys, Inc., is completing a poll of Iowa physicians. This poll is to determine our wishes as to whether the Iowa Foundation for Medical Care will be designated the Iowa Professional Standards Review Organization (PSRO). By now you should have received your mail ballot on this question. The question is this: Should you and your peers in Iowa perform PSRO duties? Or should a lay organization selected by HEW perform these functions?

The decision is yours to make. My vote will reflect the actions of the IMS House of Delegates and will support the Foundation as the PSRO. If your vote is still to be cast, I urge you to do likewise.

Sincerely,

V. L. Schlaser MD

*V. L. Schlaser, President*

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# IOWA Medical Miscellany

**PROFESSIONAL LIABILITY . . .** These professional liability developments have occured in recent weeks: (1) Governor Ray signed House File 803 into law on June 30; (2) Insurance Commissioner Huff has taken initial steps to organize the Joint Underwriting Association (JUA), doing so in hope liability insurance may be sufficiently available in the private market to not require issuance of policies by the JUA. C. H. Denser, Jr., M.D., Des Moines, is physician member of the JUA board; (3) St. Paul has indicated it will receive applications for liability insurance coverage on a broadened basis—meaning that two companies (St. Paul and Medical Protective) have expanded underwriting activity since July 1; (4) Appointment of the General Assembly Interim Study Committee has been made with initial activity just beginning. (See Question Box feature for more elaboration on claims-made coverage of St. Paul.)

**PSRO POLLING . . .** Now in process is poll of Iowa physicians to determine representativeness of the Iowa Foundation for Medical Care to serve as conditional PSRO. HEW polling process began in July and provides Iowa physicians 30 days in which to support or reject IFMC as the PSRO. July 14 letter from IMS President V. L. Schlaser, M.D., urged member support for the IFMC.

**PEER REVIEW ACTIVITY . . .** In first 6 months of 1975, the Iowa Foundation for Medical Care received 525 cases for peer review consideration. In the same period 461 cases were reviewed and resolved. The cases have come from 21 sources.

**HONOR TAYLOR . . .** Donald L. Taylor, who retired as IMS Executive Vice President June 1, was honored at a July 23 dinner held in conjunction with summer meeting of the Society's Executive Council. Representatives of the AMA and various state medical associations attended the dinner. Mr. Taylor is continuing to serve the IMS in an advisory capacity.

**COMPLETE MOVE . . .** Move of the Blue Cross/Blue Shield offices from the Liberty building to the new Ruan building has been completed in Des Moines.

**CPT GROWTH . . .** Blue Shield reports approximately 35% of its claims are being received with AMA/CPT coding included. Hope is the percentage will continue to increase.

**HEALTH PLANNING . . .** Recently formed interim board met July 21 to initiate compliance with P.L. 93-641 (National Health Planning and Resources Development Act). 90 Iowa counties will comprise the Health Systems Agency (HSA) being created under the law. The interim board has representatives from the 13 existing areawide health planning councils. J. E. Tyrrell, M.D., Manchester, is IMS representative on the board, with L. O. Ely, M.D., Des Moines, as the alternate. J. E. McGee, M.D., Ft. Madison, is an additional physician board member.

**BOARD CHAIRMAN . . .** John Rhodes, Sr., M.D., Pocahontas, was elected chairman in July of newly organized State Board of Medical Examiners. Other officers are Kenneth Carrell, D.O., Columbus Junction, vice-chairman, and Howard Ellis, M.D., Des Moines, secretary.

**CME ACTIVITY . . .** IMS Committee on Medical Education and Hospitals will meet August 13 to develop plans for implementation of the IMS/AMA continuing medical education accreditation program approved by the 1975 House of Delegates.

**SCREENING PROGRAMS . . .** Multiphasic health screening activity by American Health Profiles, Inc., has prompted inquiry. AHP has operated for brief periods in several Iowa communities, appar-

*(Please turn to page 356)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 8
AUGUST 1975

## TABLE OF CONTENTS

### SCIENTIFIC SECTION

Wilson's Disease: Investigation of an Iowa Family
Larry D. Scott, M.D. . . . . 349

Illness Engendered by a Change of Clothes
David Green, M.B., B.S. . . . . 357

Cancer Case-Finding in Gross Anatomy to Stimulate Student Interest
S. A. Terman, Ph.D., W. K. Metcalf, M.D., N. F. Metcalf, M.B.B.S., and D. Miller, B.A. . . . . 360

### EDITORIALS

Our Reading Habits . . . . . 362

AMA Physicians' Recognition Award . . 362

### SPECIAL DEPARTMENTS

President's Page . . . . . 336

Iowa Medical Miscellany . . . . . 337

The Question Box
Claims-Made Form of Medical Liability Insurance Coverage . . . . . 339

State Department of Health
Revised Recommended Treatment Schedules For Gonorrhea . . . . . 342

Educationally Speaking . . . . . 346

In the Public Interest . . . . . 348
803 Enacted, Liability Study Begins

Medical Assistants . . . . . 365

About Iowa Physicians . . . . . 366

Deaths . . . . . 367

### MISCELLANEOUS

Child Abuse Center . . . . . 346

Ophthalmia Prophylactic . . . . . 364

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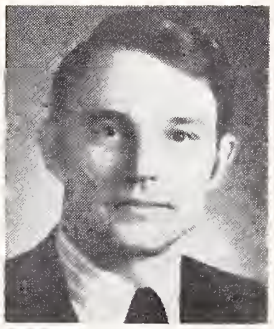
# The Question Box



by WILLIAM H. HUFF, LL.B.

*Mr. Huff is the Iowa Insurance Commissioner. His responses are presented here to assist Iowa physicians in understanding the claims-made form of medical liability insurance coverage which he has approved for sale by The St. Paul Company.*

**How does claims-made form differ from traditional occurrence form?**

Both policies provide the insured physician with financial protection against the risk of loss arising out of claims based on alleged negligence in rendering professional services. The occurrence form covers claims reported at any time in the future which resulted from professional services rendered while the policy was in force. The claims-made form covers claims reported while the policy is in force, resulting from professional services rendered during the current policy period or resulting from prior acts occurring subsequent to the retroactive date shown on the policy. The basic difference between the occurrence form and the claims-made form is that the risk insured under the occurrence form is primarily the risk of claims being reported some years in the future whereas the claims-made form primarily insures the risk of a claim being reported during the current policy period.

**Has the claims-made approach been applied to other areas of liability coverage?**

Yes. Architects and engineers professional liability insurance has traditionally been provided on a claims-made form. Also, directors and officers liability insurance, and agents and brokers errors and omissions insurance coverage is generally written on a claims-made form. Claims-made forms have also been approved for some companies writing lawyers and accountants professional liability insurance, and products liability insurance is generally written on a claims-made form.

**What are the reasons for this type of coverage?**

Professional liability insurance and products liability insurance differ from other types of liability insurance such as automobile or premises liability insurance in that in the products and professional liability lines there may be a considerable period of time between the act or occurrence which gives rise to the claim, the discovery of a potential claim, and the actual reporting of a claim. This "long tail" problem, which is aggravated by increasing claims frequency, increasing cost of claims, and constantly changing standards of professional care, creates problems for the insurer in attempting to price the cost of coverage under an occurrence form, and makes it difficult for the insured to anticipate adequate limits of liability for coverage of present acts which may result in claims some years in the future. The St. Paul Companies are no longer willing to base premiums on projections and trends of what they expect to occur in the future and then wait five or more years to see if today's pricing was correct, and have therefore elected to go to the claims-made form. The advantages of the claims-made form for the insured are that (1) the premium charged is based primarily on the actual loss experience of the company in Iowa rather than basing premiums in part on Iowa experience and primarily on trend factors and projections developed from countrywide experience; and (2) the insured is buying coverage in a particular year to cover the risk of claims reported in that year, and may there-

fore buy the amount of coverage appropriate for today's conditions rather than speculate about the amount of coverage which may be necessary to satisfy claims for today's acts which may not be discovered or reported to the company until five or more years in the future.

**How will rates for the St. Paul claims-made coverage compare with rates for coverage under an occurrence form?**

Since coverage is limited to claims reported during the policy year resulting from professional services rendered after the beginning date of coverage, and it is not until the fifth year of coverage that most claims resulting from professional acts rendered in the first year of coverage will have been reported, premiums for the first, second, third, and fourth years of coverage under the claims-made form will be less than an adequate occurrence policy rate would have been for those years. The premiums for the claims-made policy will graduate upward during the first four years of coverage to reflect the company's increasing exposure to loss with each additional year of coverage until the fifth year of coverage when the claims-made rate becomes "mature." The "mature" claims-made rate will be roughly equivalent to an adequate occurrence policy rate in the same year.

A comparison of rates under the claims-made and occurrence types of coverage must include the cost of coverage after the insured terminates his policy with the insurer since experience has shown that many claims will not be reported to the insurer until several years after the professional act giving rise to the claim occurred. There is no "reporting endorsement" with the occurrence policy since the policy itself covers claims incurred while the policy was in force no matter how many years later the claim or incident is actually reported to the company. The St. Paul Companies guarantee to offer the insured who terminates his claims-made policy with the company a "reporting endorsement" which will extend the period of time for which claims resulting from professional services rendered while the policy was in effect may be reported. The reporting endorsement will normally be sold in three annual installments: the first installment taking care of any claims reported within one year of the termination of the insured's claims-made policy, the second installment covering the second year, and the third installment covering claims reported at any time in the future arising out of acts performed while the claims-made policy was in force. The rates for each of the reporting coverage installments will depend on the claims climate in the state at the time the reporting endorsement is sold.

Although the company cannot know, at this time, what the future claims climate will be, and therefore cannot set and guarantee a rate now, the rate for each reporting installment will be less than the "mature" claims-made rate at the time the endorsement is sold, and the cost of the three reporting installments will graduate downward as a percentage of the mature claims-made premium each year as the company's exposure to loss is reduced. The rates for the reporting endorsement as well as the rates for the claims-made policy will be subject to the review of the Insurance Department.

As previously noted, rates for claims-made policies will be based on claims experience actually reported to the company and will project only months ahead, not years as under an occurrence policy. Under an occurrence policy, actual loss experience is not only trended to reflect increasing frequency of claims and higher average costs per claim, but it is also weighted to include reserves for claims incurred but not yet reported (IBNR) to the insurer. Since insurers are required by law to establish reserves for payment of every legitimate claim incurred during a policy period so that these claims may be satisfied sometime in the future even if the company stopped writing any new business, the Insurance Department has accepted these traditional actuarial techniques of rate-making, but it is extremely difficult to prove or disprove the adequacy of rates weighted heavily for IBNR and projections into the future. Claims-made rates which are based on experience actually reported to the insurer should be more responsive to conditions affecting claims and will permit closer scrutiny regarding adequacy or excessiveness of rates by the Insurance Department.

**A major concern of physicians is over the situation which arises when the need exists to terminate coverage for reasons of moving, retirement, disability or death. How are these provided for?**

As noted above, the St. Paul claims-made policy includes guarantee to offer a reporting endorsement to extend coverage for the reporting of claims after the doctor terminates his claims-made coverage. The reporting endorsement will automatically be delivered to the doctor or his agent after the policy is terminated, and the doctor (or his estate) must take affirmative action to reject this coverage if the physician does not want to purchase the reporting endorsement by refusing to accept the offered coverage, cancellation of the reporting endorsement, or non-payment of premium. Every physician will be offered the opportunity to purchase the reporting endorsement even if his claims-made policy has been cancelled by the company for severe adverse claims experience or non-payment of premium.

In the event of the death of an insured physician, his estate will have an option of buying the reporting endorsement which would normally be sold in three annual installments, for one lump sum based on the current premium for the three annual installments plus a surcharge reflecting claim frequency and severity trends.

If the insured physician moves to another state, and continues his coverage with St. Paul, there would be no necessity to purchase the reporting endorsement until the physician ceased to practice or terminated his coverage with St. Paul.

If the insured physician becomes disabled and can no longer practice medicine, he or she will need the reporting endorsement but may have trouble purchasing the coverage because of unanticipated expenses incurred as a result of the disability. The physician may insure against this contingency by purchasing a disability waiver of premium endorsement to the claims-made policy, which would provide for a waiver of premium for the reporting endorsement if the physician is totally disabled for a period of least six months.

**A claims-made policy reportedly covers all claims filed within the year of its existence. What advice would you give Iowa physicians about the filing of information about incidents?**

If an unusual incident occurs during or following treatment, surgery, or hospitalization which the physician feels may later give rise to a claim, the physician may report that incident to the company prior to any claim being presented by a dissatisfied patient and the company will provide coverage for the incident reported during the policy year. Earlier reporting of potential claims is encouraged because it enables the company to conduct an investigation of the incident while the facts are still fresh and available, and hopefully ultimately reduce claim costs by providing a better defense if a claim is eventually presented.

**What complications present themselves if the primary and umbrella coverages are with different carriers?**

Normally, the professional liability umbrella is written on a "following form" which means that the excess limits coverage will track with the policy provisions of the primary coverage, and there should not be a problem with a change in the underlying policy provisions. This does not mean that the umbrella carrier is required to guarantee coverage for the reporting endorsement, but, in general, umbrella carriers have expressed a preference for writing over claims-made coverage and will write excess limits over the reporting endorsement as well as the basic policy. However, a physician who has his or her umbrella coverage with a carrier other than St. Paul should consult with his agent about any possible problem regarding the change to claims-made.

**The St. Paul claims-made policy has deleted the requirement that the company obtain the doctor's consent before settlement of a claim. How will this affect the doctor?**

Not only St. Paul, but most of the insurers writing professional liability insurance are amending their policy to delete the requirement of obtaining the doctor's consent prior to settlement. The provision requiring the insured's consent as a condition of settlement has been unique to professional liability policies and the insurers feel that requirement has in some cases delayed settlement and thus increased claim costs and resulted in increased premium rates. The insurers will continue to work closely with the insured physician in determining whether the claim is defensible, and will attempt to settle meritorious claims at a reasonable cost while continuing to resist those claims that appear to be without merit.

# REVISED RECOMMENDED TREATMENT SCHEDULES FOR GONORRHEA

The U. S. Public Health Service recently updated its suggested therapy for gonorrhea. The revised recommended PHS gonorrhea treatment schedules are presented here. Attention is invited to the change in dosage of spectinomycin hydrochloride. Expanded and specific recommendations are made regarding treatment of pharyngeal infections, gonorrhea in pregnant patients, disseminated gonococcal disease and infections in pediatric patients.

GONORRHEA

*Recommended Treatment Schedules—1974*

Note: *Physicians are cautioned to use no less than the recommended dosages of antibiotics.*

## UNCOMPLICATED GONOCOCCAL INFECTIONS IN MEN AND WOMEN

*Drug Regimen for Choice:*

Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, together with one gram of probenecid, by mouth, just before the injections.

*Alternative Regimens:*

A. Patients in whom oral therapy is preferred: Ampicillin, 3.5 gm by mouth, together with one gram probenecid by mouth, administered at the same time. There is evidence that this regimen may be slightly less effective than the recommended APPG regimen.

B. Patients who are allergic to the penicillins (pencillin G, Ampicillin) or probenecid: *

1. Tetracycline hydrochloride, 1.5 gm initially by mouth, followed by 0.5 gm by mouth four times per day for 4 days (total dosage, 9.5 gm). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as single dose therapy.

2. Spectinomycin hydrochloride, 2.0 gm intramuscularly, in one injection.

*Treatment of Sexual Partners:*

Men and women with known recent exposure to gonorrhea should receive the same treatment as individuals known to have gonorrhea. Male sex partners of persons with gonococcal infection must be examined and treated because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men.

*Follow-up:*

Follow-up urethral and other appropriate cultures should be obtained from men, and cervical, anal and other appropriate cultures should be obtained from women, 7 to 14 days after completion of treatment.

*Treatment Failures:*

Most recurrent infection after treatment with the recommended schedules is due to reinfection. True treatment failure after therapy with penicillin, ampicillin or tetracycline should be treated with 2.0 gm of spectinomycin intramuscularly.

*Postgonococcal Urethritis:*

Tetracycline, 0.5 gm, four times daily by mouth, for at least 7 days.

*Pharyngeal Infection:*

Pharyngeal gonococcal infections may be more difficult to treat than anogenital gonorrhea. Post-treatment cultures are essential followup for pharyngeal infection. The schedules of ampicillin and spectinomycin recommended for anogen-

* Allergy to penicillin, ampicillin, probenecid, or previous anaphylactic reaction. USDHEW, PHS, CDC, BSS, VDCD, Atlanta, Georgia. Ref: MMWR Vol.23 No.40 Oct. 5, 1974.

ital gonorrhea are ineffective in pharyngeal gonorrhea. Patients with pharyngeal gonorrhea whose infection is not eradicated after treatment with 4.8 million units of APPG plus one gram of probenecid, may be treated with 9.5 gm of tetracycline in the dosage schedule outlined above (Alternative Regimens).

*Syphilis:*

All patients with gonorrhea should have a serologic test for syphilis at the time of diagnosis. Seronegative patients without clinical signs of syphilis, who are receiving the recommended parenteral penicillin schedule, need not have follow-up serologic tests for syphilis. Patients treated with ampicillin, spectinomycin, or tetracycline should have a follow-up serologic test for syphilis after 3 months to detect untreated syphilis.

Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

*Not Recommended:*

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have *NO* place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

## TREATMENT OF UNCOMPLICATED GONORRHEA IN PREGNANT PATIENTS

A. For women who are not allergic to penicillin: Use the regimens of aqueous procaine penicillin G plus probenecid, or use ampicillin plus probenecid, as defined above.

B. Pregnant patients who are allergic to penicillins (there are several possible alternative regimens, each of which has potential disadvantages):

1. Erythromycin, 1.5 gm orally, followed by 0.5 gm four times a day for 4 days, for a total of 9.5 gm. This regimen is safe for mother and fetus, but efficacy has not been established. Erythromycin estolate should not be used in patients with underlying liver disease.

2. Cefazolin, 2 gm intramuscularly, with 1.0 gm of probenecid. Because of the possibility of cross-allergenicity between penicillins and cephalosporins, this regimen should not be used in a patient with a history of penicillin anaphylaxis.

3. Spectinomycin, 2 gm intramuscularly. This is an effective dose, but safety for the fetus has not been established.

*Contraindicated:*

Tetracycline should not be used for uncomplicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

## ACUTE SALPINGITIS (PELVIC INFLAMMATORY DISEASE)

The diagnosis of acute salpingitis should be considered in women with acute lower abdominal pain and adnexal tenderness on pelvic examination. Since there are no completely reliable clinical criteria on which to distinguish gonococcal from nongonococcal salpingitis, endocervical cultures for *N. gonorrhoeae* are essential in such patients. Therapy, however, should be initiated immediately, without waiting for the results of the cultures.

A. *Hospitalization:* Hospitalization should be strongly considered for women with suspected salpingitis in these situations:

1. Uncertain diagnosis, where surgical emergencies must be excluded.
2. Suspicion of pelvic abscess.
3. Pregnant patients with salpingitis.
4. Inability of the patient to follow an outpatient regimen of oral medication, especially because of nausea and vomiting.
5. Failure to respond to outpatient therapy.

B. *Antimicrobial Agents:* Controlled studies of the treatment of acute salpingitis are not available. Initial management must *AT LEAST* be adequate for gonococcal salpingitis. These regimens are known to be adequate for the treatment of gonococcal salpingitis:

1. Outpatients:

a. 1.5 gm tetracycline hydrochloride, given as a single oral loading dose, followed by 500 mg, taken orally, four times daily for 10 days.

b. Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, *OR* 3.5 gm of oral ampicillin. One gram of oral probenecid is given along with either penicillin or ampicillin, and both are followed by 500 mg of ampicillin, taken orally, four times daily for 10 days.

2. Hospitalized patients:

a. Aqueous crystalline penicillin G, 20 million units, given intravenously each day until clear-cut improvement occurs, followed by 500 mg of ampicillin taken orally four times daily, to complete 10 days of therapy. The need for additional or alternative antibiotics for the treatment of

nongonococcal salpingitis requires further study. Since it is impossible to distinguish gonococcal from nongonococcal salpingitis clinically, many physicians also use an aminoglycoside in addition to penicillin and/or antibiotics which are effective against *Bacteroides fragilis* as initial therapy.

b. Tetracycline hydrochloride, 500 mg, given intravenously four times daily until improvement occurs, followed by 500 mg taken orally four times daily, to complete 10 days of therapy. This regimen should not be used for pregnant women or for patients with renal failure.

3. Failure to improve on the recommended regimens does not necessarily indicate the need for stepwise additional antibiotics, but requires reassessment of the possibility of other diagnoses and of the specific microbial etiology.

C. The effect of the removal of an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis requires further study.

D. *Adequate treatment of women with acute gonococcal salpingitis must include examination and appropriate treatment of their male sex partners because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men. Failure to treat male sex partners is a major cause of recurrent gonococcal salpingitis.*

E. Followup of patients with acute salpingitis is essential. All patients should receive repeat pelvic examinations and cultures for *N. gonorrhoeae* after treatment.

## DISSEMINATED GONOCOCCAL INFECTION

A. Equally effective treatment schedules in the arthritis-dermatitis syndrome include:

1. Aqueous crystalline penicillin G, 10 million units intravenously per day for 3 days, or until there is significant clinical improvement. This may be followed with ampicillin, 500 mg four times a day orally, to complete 7 days of antibiotic treatment.

2. Ampicillin, 3.5 gm orally, plus probenecid, 1.0 gm, followed by ampicillin, 500 mg four times per day orally, for at least 7 days.

B. In penicillin and/or probenecid allergic patients:

1. Tetracycline, 1.5 gm orally, followed by 500 mg four times a day orally, for at least 7 days. Tetracycline should not be used for complicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

2. Erythromycin, 0.5 gm intravenously every 6 hours, for at least 3 days.

C. Additional measures:

1. Hospitalization is indicated in patients who are unreliable, have uncertain diagnosis, or have purulent joint effusions or other complications.

2. Immobilization of the affected joint(s) appears helpful. Repeated aspirations and saline irrigations appear beneficial, but controlled studies of these procedures have not been performed. Open drainage of joints other than the hip is now generally discouraged in patients with gonococcal arthritis.

3. Intra-articular administration of penicillin is unnecessary, since penicillin levels in the synovial fluid of inflamed joints approximate serum levels; furthermore, intra-articular injection per se may produce a toxic synovitis.

D. Meningitis and endocarditis due to the gonococcus require high-dose intravenous penicillin therapy (at least 10 million units per day) for longer periods: usually at least 10 days for meningitis and 3-4 weeks for endocarditis.

## GONOCOCCAL INFECTION IN PEDIATRIC PATIENTS

Pediatric patients encompass those from birth to adolescence. When a child is post-pubertal and/or weighs over 100 pounds, he or she should be treated with dosage regimens as defined above for adults.

WITH GONOCOCCAL INFECTION IN CHILDREN, THE POSSIBILITY OF CHILD ABUSE MUST BE CONSIDERED.

The efficacy of therapeutic regimens for uncomplicated and complicated gonococcal infections of childhood is unproven at present.

*Prevention of Neonatal Infection:*

All pregnant women should have endocervical cultures examined for gonococci as an integral part of prenatal care.

*Prevention of Gonococcal Ophthalmia:*

A. One percent silver nitrate (do not irrigate with saline, as this may reduce efficacy).

B. Ophthalmic ointments containing tetracycline, erythromycin, or neomycin are also probably effective.

C. NOT RECOMMENDED: Bacitracin oint-

ment (not effective) and penicillin drops (sensitizing).

*Management of Infants Born to Mothers With Gonococcal Infection:*

Orogastric and rectal cultures should be taken from all patients. Blood cultures should be taken if septicemia is suspected. Aqueous crystalline penicillin G, 50,000 units/kg/day, should be administered in two daily doses intravenously, if cultures or Gram-stained smears reveal gonococci. The duration of therapy should be determined by clinical response. In suspected septicemia, an aminoglycoside should also be administered.

*Neonatal Disease:*

A. Gonococcal ophthalmia: Patient should be hospitalized. Antimicrobial agents: Aqueous crystalline penicillin G, 50,000 units/kg/day, in two or three doses intravenously for 7 days, PLUS frequent saline irrigations and instillation of penicillin, tetracycline or chloramphenicol eyedrops.

B. Complicated infection: Arthritis and septicemia should be treated by hospitalization and administration of aqueous crystalline penicillin G, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, 75,000-100,000 units/kg/day, in two doses, for 7 days. Meningitis should be treated with aqueous crystalline penicillin G, 100,000 units/kg/day, divided into two or three daily intravenous doses and continued for at least 10 days.

*Childhood Disease:*

Gonococcal ophthalmia should be treated with hospitalization and by the administration of aqueous crystalline penicillin G intravenously, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, intramuscularly, 75,000-100,000 units/kg/day, in two doses, for 7 days, *PLUS* saline irrigations and instillation of penicillin, tetracycline or chloramphenicol eyedrops. Topical antibiotics *alone* are *NOT* recommended in therapy of gonococcal ophthalmitis. The source of the infection must be identified.

Uncomplicated vulvovaginitis and urethritis usually do not require hospitalization. Both may be treated at one visit with aqueous procaine penicillin G, 75,000-100,000 units/kg intramuscularly, and probenecid, 25 mg/kg by mouth. Topical and systemic estrogen therapy are of no benefit in vulvovaginitis. All patients should have follow-up cultures, and the source of infection should be identified, examined and treated.

Infection complicated by peritonitis or arthritis should be treated in hospitalization and administration of aqueous crystalline penicillin G, intravenously, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, 75,000-100,000 units/kg/day intramuscularly, in two doses for 7 days.

Treatment of patients with allergy to penicillin: Patients under 6 years of age should be treated with erythromycin, 40 mg/kg/day, in four doses by mouth, for 7 days, for uncomplicated disease. Complicated disease should be treated with cephalothin, 60-80 mg/kg/day in four doses intravenously, for 7 days. Patients older than 6 may be treated with an oral regimen of tetracycline, 25 mg/kg, as an initial dose, followed by 40-60 mg/kg/day in four doses, for 7 days, or an intravenous regimen consisting of tetracycline, 15-20 mg/kg/day, in four doses, for 7 days.

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AN EQUAL OPPORTUNITY EMPLOYER

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## TESTS AND TESTEES

Just like Pavlovian dogs, most of us have been conditioned to exhibit an avoidance reaction when faced with a paper-and-pencil test, or even the prospect of one. We may cheerfully "show off" the range and depth of our knowledge and skill as we talk to patients and colleagues; but hand us a written examination as a way to display our talents, and most of us become negative, devious or even actively hostile. Nor is it a matter of our feeling fearful at trying to solve problems. Good grief, no—physicians as a class are continually immersed in some of the most challenging and vexatious riddles and distresses which the most malevolent circumstances of nature can summon.

Why then do the mighty tremble? I fear it's because of a polluted segment of the otherwise bountiful harvest of our educational system. Unfortunately, teachers at all levels use tests as ends in themselves, rather than as means to achieve desirable ends. "But you can't measure clinical skills with multiple-choice questions," goes the argument. Yet we must admit that such a test can indeed sample our basic fund of information, without which a practitioner can't possibly provide good clinical care today. Many of the "old-timers" might be amazed at the ingenious and imaginative kinds of test items now employed in truly well-constructed measuring instruments such as the National Board Examinations or its offspring, the FLEX exam used for licensure. The so-called "patient-management problem" seems a fine step forward in the effort to attain a scorable, pencil-and-paper test that simulates real clinical experience. There must (I feel deep in my bones) be not a perfect but a reasonably good correlation between satisfactory performance on such exams, and being a good doctor. But no one can really test that assertion since the definition of "a good doctor," at least in measurable attributes, still eludes us.

If tests were used as opportunities for communication between teacher and student, as frequent occasions for self-appraisal and the noting of progress or problems, and if testing occurred often enough to hyposensitize us and prevent panic reactions, then we might reach a point—I wonder if it really is yet too late—where each of us would welcome a daily dose of such a challenge from the latest quiz just as we now greet a dividend check. Yes, it might happen, and I hope sooner than that day when the lion and the lamb lie down together and men beat spears into pruning hooks.

## CHILD ABUSE CENTER

A Regional Child Abuse and Neglect Center is to be established at The University of of Iowa with a three-year $750,000 grant from the National Institute of Child Health and Human Development. The Center will serve four states and provide services primarily to professionals, rather than direct service to abuse-neglect victims and their families. The Center will be located at the Oakdale campus.

Principal investigator for the grant is Gerald Solomons, M.D., professor of pediatrics and director of the Child Development Clinic.

The program expects to be particularly supportive of services in rural and semi-rural communities.

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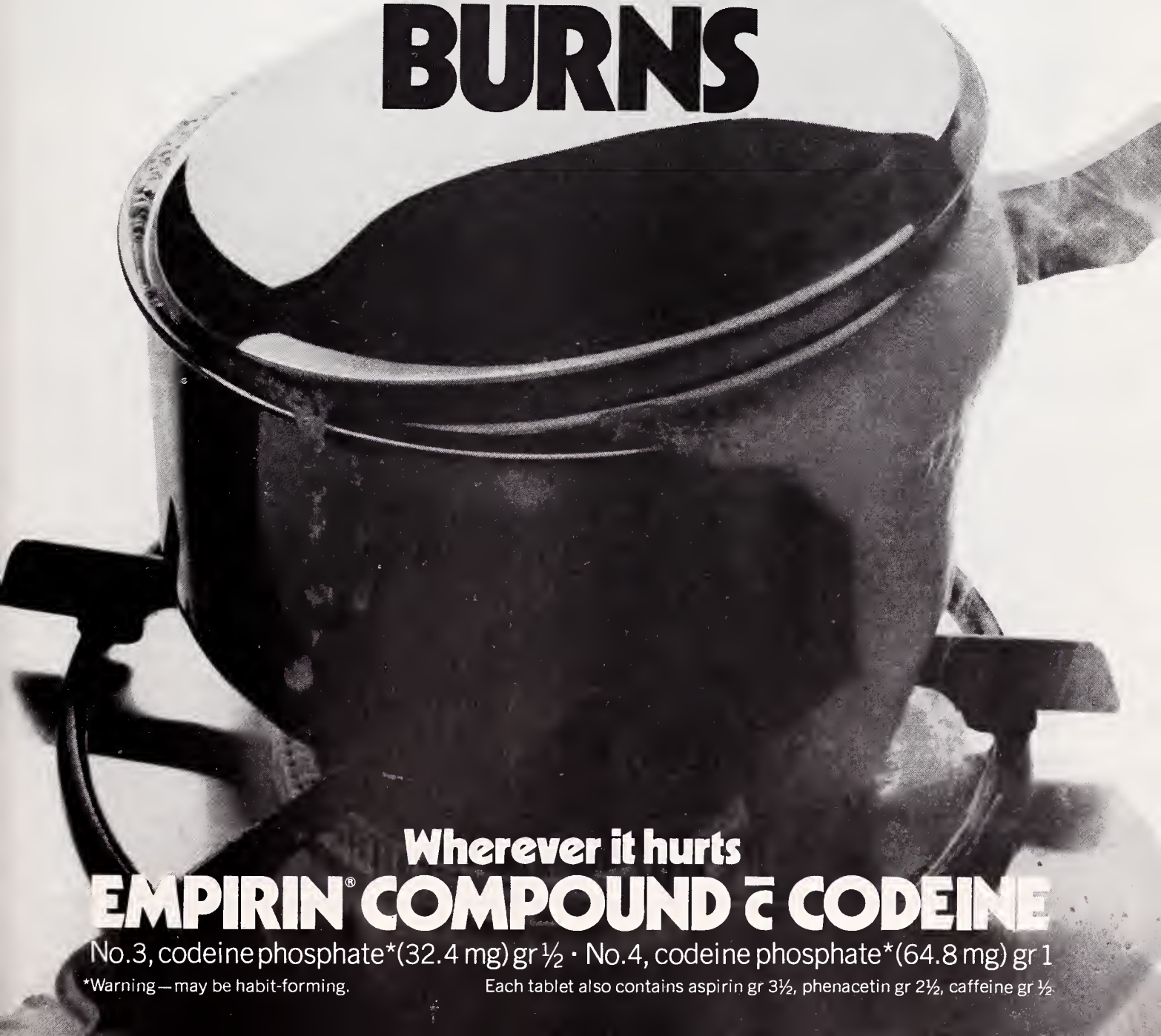

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# 803 ENACTED, LIABILITY STUDY BEGINS

THE RECORD should show the State of Iowa has given *positive recognition* to a critical problem which has hit many parts of the country. By its passage recently—and the subsequent enactment June 30—of House File 803, the Iowa General Assembly has responded tangibly to the extremely complex and volatile medical liability insurance situation.

The new state statute which emanates from House File 803 embodies various provisions which hopefully will have a remedial result. No claim has been made by anyone that the new law will resolve with any totality the difficulties which have emerged in past years.

What's happened since enactment of H.F. 803 to justify the opening reference to *positive recognition?*

Comments from and actions of the insurance companies have been favorable. Those companies that provide most of the liability coverage to Iowa physicians have stepped up their marketing. While electing to proceed with extreme caution and while imposing certain limitations and/or modifications, these companies nonetheless have indicated they will accept applications from Iowa physicians. This is heartening after a six-month period in which this coverage was practically non-existent or prohibitive cost-wise. We do not mean to imply that premium costs have gone down or even stabilized. On the contrary, rates have continued to increase—a few to annual levels of 15,000 or so dollars.

But the new legislation must be construed as a starting point, as a foundation on which to build a more lasting solution. Reports relayed to the Society from the recent national meeting of the National Association of Insurance Commissioners and from other sources carry a favorable reaction to Iowa's new legislation. It is not as far-ranging as that enacted in Indiana or Idaho, but it constitutes, as has been stated, a reasonable preliminary response.

In addition to the several tort reform measures embodied in the new law, there is provision for a two-year Joint Underwriting Association. The JUA is a temporary mechanism to assure availability of coverage should the private market disappear. The decision when to institute the JUA is made by the Insurance Commissioner. JUA governing mechanisms have been established over the past four weeks. The efforts of many individuals and organizations have been involved in this process. This having occurred, however, it is now important to add that it is the expressed hope of the Insurance Commissioner and others that the JUA will not have to issue policies. It is hoped the private market will meet the need.

Those provisions (besides the JUA) contained in the new Iowa statute have been explained briefly on many occasions in Society publications. To those who understand, they attempt to (1) improve the statute of limitations, (2) impose the collateral source rule, (3) eliminate the ad damnum cause, (4) provide an informed consent option, (5) call for the involvement of the court in contingent fee determination, and (6) grant peer review immunity to physicians.

What's next?

Obviously, it will be the ongoing matter of finding and maintaining tolerable insurance coverage for Iowa physicians. It will be the effective implementation of the new law—including the possibility of the JUA.

But further, in additional recognition of the problem and in an attempt to identify permanent solutions, the Iowa General Assembly authorized an interim study committee. Appointment of 10 legislators to serve on this study committee has occurred. These lawmakers have at their disposal $25,000 to evaluate the situation and to make a report to the Assembly in 1976, including with the report any legislative proposals.

Members of the committee deserve commendation for taking on this important assignment. They include: Senate—William Palmer, Des Moines; Robert Carr, Dubuque; Warren Curtis, Cherokee; Willard Hansen, Cedar Falls; Lowell Junkins, Montrose. House—Horace Daggett, Kent; Maurice Hennessey, Ryan; Robert Kreamer, Des Moines; Arthur Small, Iowa City; Craig Walter, Council Bluffs.

The Iowa Medical Society is enthusiastic about the potential of this study. It wishes to be helpful and supportive to the fullest extent possible.

# IN THE PUBLIC INTEREST

SCIENTIFIC ARTICLES

# Wilson's Disease: Investigation of an Iowa Family

LARRY D. SCOTT, M.D.
Iowa City

*An Iowa family is studied for the presence of Wilson's Disease. The availability of effective therapy makes it important to evaluate young patients with hepatic disorders.*

When S. A. Kinnier Wilson in 1912 reported six cases of a progressive, ultimately fatal neurological disease of the extrapyramidal system associated with hepatic cirrhosis, emphasis was placed on the prominence of neurological symptoms; he concluded that although cirrhosis is a constant feature at post-mortem, no signs of liver disease are present during life.[1] Since then, numerous reports have appeared describing the clinical features of this inborn error of copper metabolism and it has become apparent that clinical liver disease is not only a common presentation for these patients, but may, in addition, lead to demise at an early age prior to the appearance of any symptoms referable to the central nervous system. We have recently followed a patient who for two years carried a diagnosis of chronic active hepatitis; reassessment of the clinical picture led to an eventual diagnosis of Wilson's Disease and two additional cases were discovered when the family was evaluated. This report describes the clinical features of the disease in this family and the means by which the diagnoses were confirmed.

Dr. Scott prepared this paper during his fellowship in gastroenterology at The University of Iowa College of Medicine. Dr. Scott is now a member of the Department of Internal Medicine, Ireland Army Hospital, Ft. Knox, Kentucky.

## CASE REPORTS

(1) R. H. This was a 17-year-old Caucasian male when he was first seen at the University of Iowa Hospitals and Clinics in July, 1971. Six years previously viral hepatitis had been suspected and in the spring of 1971, mild jaundice recurred. Gynecomastia and splenomegaly were present, but the liver was not enlarged and the neurological examination was normal. In the laboratory, the total bilirubin was 2.8 mg per dl, SGOT was 36 IU per ml (normal, 8-40), alkaline phosphatase was 6.6 BLU (normal, 1-2.5), albumin was 2.1 gm per dl, and the prothrombin time was 16 seconds (control, 12). Rare LE cells were said to be present. Liver biopsy was not done because of impaired clotting functions.

Over the course of the next two years, no changes were noted. Prednisone was prescribed for 18 months because of a suspected diagnosis of chronic active hepatitis, but no improvement was noted. In May, 1973, the total bilirubin was

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF AUGUST, 1975.

TABLE I

PARAMETERS OF COPPER METABOLISM

| Patient | Urinary Copper (μg/24 hr)[1] No Treatment | On Penicillamine | Hepatic Copper[2] (μg/gm dry wt) |
|---|---|---|---|
| RH ..... | 280 | 7400 | 176, 79 |
| WH ..... | 240 | 1526 | 588, 594 |
| LH ..... | 580 | 3770 | |

[1] Normal adult: < 50 μg/24 hours.
[2] Normal adult: 20-50 μg/gm dry weight.

2.3 mg per dl, SGOT was 51 IU per ml, alkaline phosphatase was 162 IU per ml, and the prothrombin time was 14 seconds (control, 12). Mild pancytopenia due to hypersplenism persisted. Reassessment of this patient's record indicated incomplete evaluation for Wilson's Disease; subsequently a low serum ceruloplasmin concentration (Figure 1), elevated urinary copper (Table I), and the presence of Kayser-Fleischer rings documented that diagnosis.

Therapy with low copper diet and penicillamine, 250 mg four times daily, was initiated with an appropriate cupriuresis (Table I). An appendectomy for acute appendicitis was required in August, 1973, and was carried out without difficulty. Management of the patient in the ensuing months was, however, difficult as the patient's abuse of alcohol, marihuana, hallucinogens, and probably narcotics—noted periodically since 1971—increased. Therapy was not adhered to and the patient was frequently away from home for weeks at a time without medication. Subsequently he was admitted to his local hospital in February, 1974 and eventually transferred to the University of Iowa Hospitals on February 11, 1974

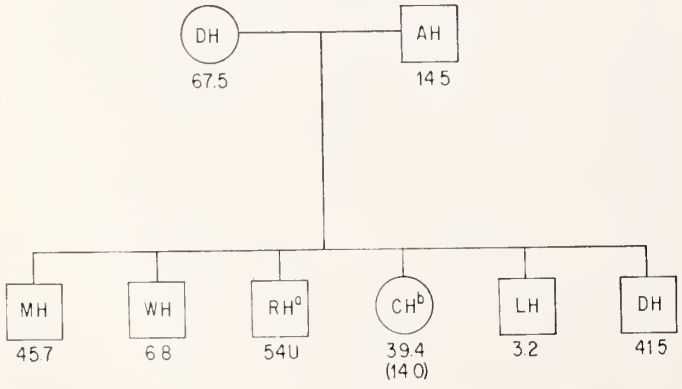



Figure 1. Pedigree of the family; the numbers beneath each symbol are the serum concentrations of ceruloplasmin in mg per dl for each family member. [a] The propositus and now deceased; ceruloplasmin results are expressed in units (normal, 280-570). [b] The values indicated were obtained when C. H. was 3 months pregnant (39.4) and 6 weeks post-partum (14.0).

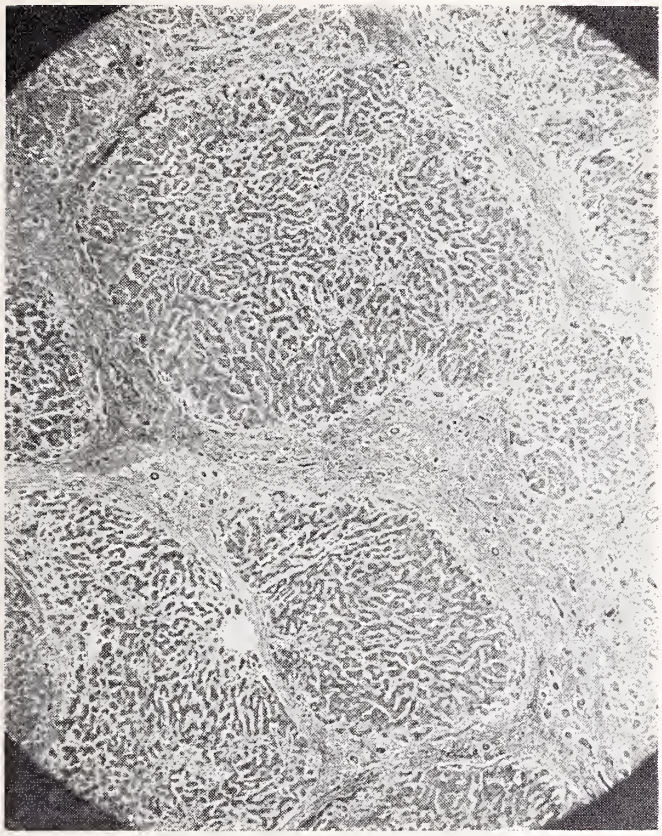
for evaluation of the sudden appearance of a bizarre, poorly responsive state associated with akinetic mutism and dystonic posturing of the extremities. Physical examination was otherwise unchanged; in the laboratory, the total bilirubin was 5.4 mg per dl, SGOT was 66 IU per ml, alkaline phosphatase was 150 IU per ml, and the prothrombin time was 17 seconds (control, 11). Lumbar puncture, EEG, brain scan and other studies were within normal limits; therapy including penicillamine and a short course of

Figure 2. The liver in Case I (R. H.); post-necrotic cirrhosis is suggested by the nodules of variable size.

L-Dopa did not influence the course, which was progressively downhill.

Numerous febrile episodes and progressive hypoalbuminemia with appearance of ascites complicated the course and the patient expired April 21, 1974. Post-mortem examination revealed a small multilobular liver (Figure 2), splenomegaly and chronic cholecystitis. The brain was mildly congested, but otherwise normal, and sectioning revealed no gross abnormalities. Histologically, post-necrotic cirrhosis was evident (Figure 3) and the basal ganglia exhibited only mild neuronal loss and mild glial proliferation.

(2) W. H. After the diagnosis of Wilson's Disease was made in R. H., family screening revealed two additional members with low ceruloplasmin levels. W. H., age 13, was admitted to the University of Iowa Hospitals, September 24, 1973; he was essentially free of symptoms. Physical examination was significant, revealing a total hepatic breadth of 13 cm with a firm edge palpable 4 cm below the right costal margin. No splenomegaly was present and the neurological examination was normal. Hemogram, prothrombin time, and total bilirubin were normal; the SGOT



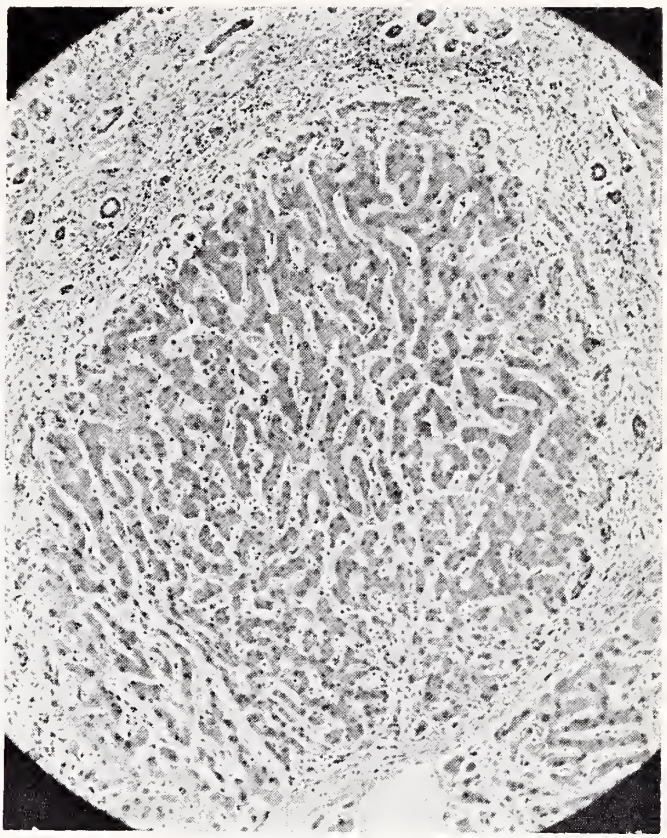
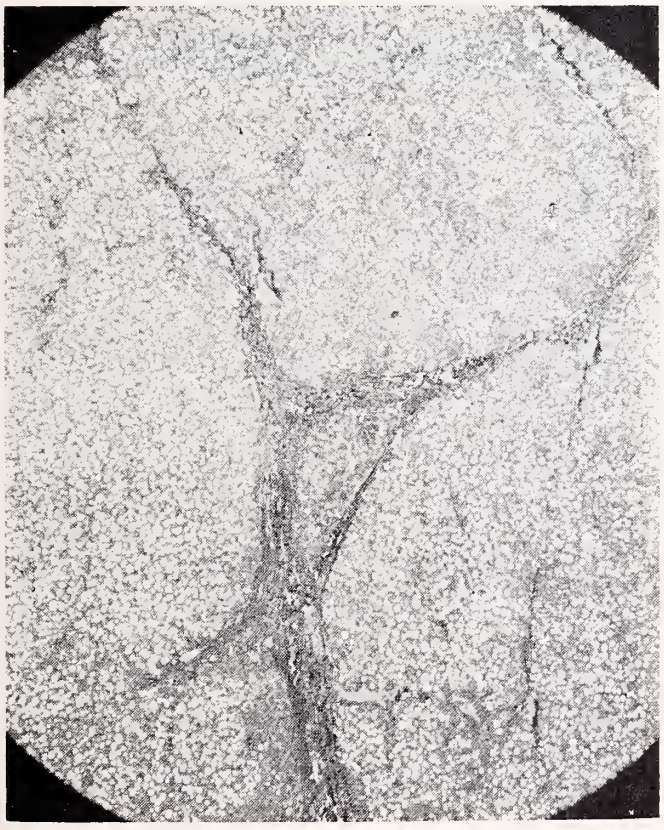


Figure 3. Histopathology of the liver in Case 1 revealing on the left (40×) broad bands of connective tissue separating nodules of well-preserved hepatic architecture; on the right (100×), the absence of a central vein is characteristic of a regenerative nodule.



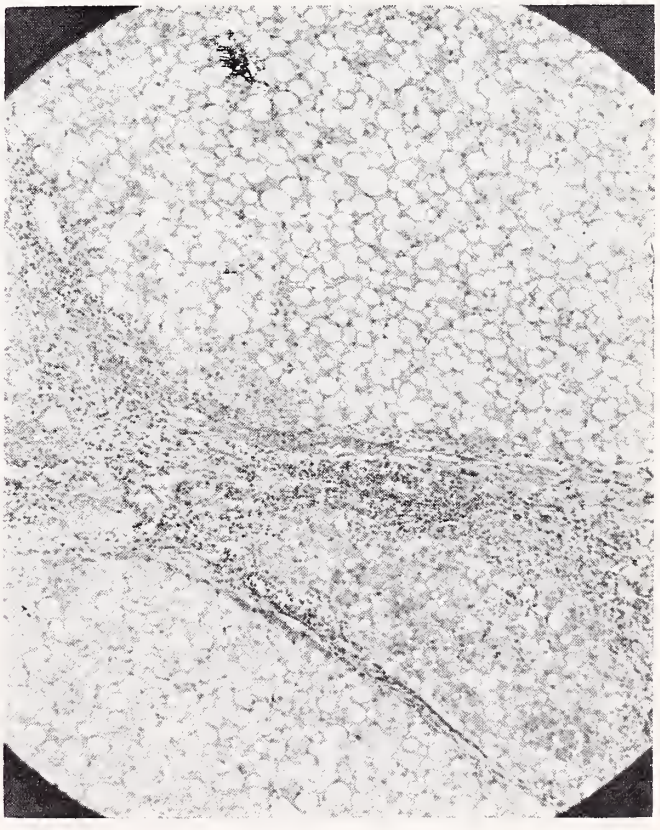


Figure 4. Histopathology of the liver in Case 2 (W. H.) revealing on the left (40×) extensive fatty metamorphosis and thin bands of connective tissue connecting portal triads; on the right (100×), no necrosis is evident, but chronic inflammatory cells are present in the fibrous tissue.

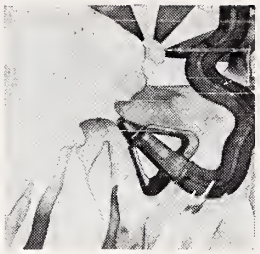
was 82 IU per ml and the alkaline phosphatase was 435 IU per ml; Kayser-Fleischer rings were not present.

Open liver biopsy revealed an enlarged nodular liver which histologically showed extensive fatty metamorphosis with early cirrhosis (Figure 4). When quantitation of hepatic copper revealed significant elevation, therapy with penicillamine, 250 mg three times daily, and a low copper diet was begun. An adequate response was evident in urinary copper excretion and the patient has done well, remaining free of symptoms. Examination in February, 1974, revealed no change in either the physical or laboratory findings.

(3) L. H. This 22-year-old brother of R. H. was also found to have suppressed serum ceruloplasmin concentration (Figure 1). Upon admission to the University of Iowa Hospitals September 25, 1973, the patient cited a history of excellent health and specifically, there was no history of liver disease. Careful questioning indicated that perhaps he was having some gait difficulty and had noted some sialorrhea, but no abnormalities were noted on neurological examination. The liver was not enlarged, nor were there other significant findings with the exception of prominent Kayser-Fleischer rings. All laboratory parameters including hemogram and chemistry profile were within normal limits. Liver biopsy was not done. A base line urinary copper was obtained and therapy with penicillamine and low copper diet was begun; an appropriate response was noted (Table I). The patient has remained symptom-free since that time.

(4) Other family members. M. H., C. H., and D. H. were all felt to be free of disease when normal serum ceruloplasmin concentrations were returned and both physical and laboratory examination had revealed no abnormalities. When, however, it was learned that C. H., age 21, was pregnant when initially screened, a follow-up level was determined six weeks post-partum and found to be low (Figure 1). Except for mild obesity, no abnormalities were noted on physical examination or in the laboratory. Detailed ophthalmological examination was likewise normal. Mild hypercupriuria was present, however (65 $\mu$g per 24 hours), and in April, 1974, a needle biopsy of the liver was performed. Normal histology and normal tissue levels (38 and 52 $\mu$g per gm dry weight) excluded homozygous Wilson's Disease. The patient was reassured, given no therapy and has remained symptom free. A followup serum

*(Please turn to page 354)*



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main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

**Preparation and distribution of patient drug information**

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

**Realistic problems must be considered**

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

**What information is appropriate?**

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

**Positive aspects of patient drug information**

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

---

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

**Emotionally unstable patients pose a special problem**

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

**Legal implications of the patient package insert**

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

**How do we handle an insert for medication used for a placebo effect?**

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

**Preparation of the package insert**

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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ceruloplasmin concentration with the patient on oral contraceptives was once again normal (39.6 mg per dl).

## DISCUSSION

A rare, ultimately fatal disease if untreated, involving aberrant copper metabolism, Wilson's Disease nevertheless is a recognizable clinical entity which can be accurately diagnosed and for which generally effective therapy exists. Emphasis in this report is on the hepatic manifestations of Wilson's Disease. It would appear any patient presenting with evidence of chronic liver disease in the first three or four decades of life should be suspected of having this diagnosis until the appropriate evaluation is carried out to exclude it.

Wilson's Disease is an autosomal recessive inherited disorder with a gene frequency as high as one in 200 in some reports;[2] nevertheless, a diagnosis of this disease is uncommon with only 18 cases being recognized at this institution since 1938. This statement should be qualified, however, by noting that prior to the introduction of techniques to measure parameters of copper metabolism, the diagnosis could only be made in patients who exhibited the pathognomonic Kayser-Fleischer ring, a brown-green copper deposit near the limbus of the cornea. W. H. (Case 2) emphasizes the point that advanced liver disease may be present in the absence of demonstrable Kayser-Fleischer rings (although neurological disease is never seen in the absence of these rings). Availability of means to determine ceruloplasmin and copper concentrations in body fluids and tissue has permitted a much higher diagnosis rate in recent years.

It has become obvious from numerous reports of patients with Wilson's Disease that hepatic manifestations must be thought of as a spectrum of possibilities ranging from clinically inapparent disease to end stage cirrhosis with portal hypertension, esophageal varices, and hepatic encephalopathy.[3] This spectrum is portrayed to an extent in the three patients presented in this report, and we have seen one patient in the past who had fulminant hepatic dysfunction on the basis of Wilson's Disease leading to rapid deterioration and death within three months of the appearance of symptoms at age 10. Recently attention has been called to the fact that Wilson's Disease must be considered in the differential diagnosis of patients presenting with chronic hepatitis.[4] Such was the case with the propositus, although critical review of the record indicates that such a diagnosis may not have been justified with the essentially normal SGOT levels noted during those two years. Nevertheless, it has been speculated that up to 5% of patients with a chronic hepatitis syndrome may in fact have Wilson's Disease[4] and, in light of the availability of specific therapy, it should be excluded in all young patients in whom a diagnosis of chronic active hepatitis is also being considered.

Whether R. H. also had neurological disease on the basis of Wilson's Disease remains somewhat speculative. It had originally been considered that the antisocial behavior he exhibited might be on this basis as well as the acute encephalopathy prior to death. Yet the relatively unimpressive central nervous system findings at post-mortem cast some doubt on this and one wonders about the role played by drug abuse.

Once the diagnosis of Wilson's Disease is considered, appropriate effort should be made to confirm or reject the diagnosis. The classic biochemical features of Wilson's Disease are low or absent serum ceruloplasmin concentration, low total serum copper concentration with an increase in non-ceruloplasmin (or albumin-bound) copper, and increased urinary copper excretion.[5] These features must be considered generalities, however, and exceptions have been documented repeatedly. The serum ceruloplasmin concentration, the most often used screening test for Wilson's Disease, may also be low in up to 10% of heterozygotes who are free of disease.[2] In addition, low levels have been reported in nephrotic syndrome, malabsorption syndromes and protein-losing enteropathies, protein-calorie malnutrition, and rarely severe hepatic dysfunction of other causes.[6] On the other hand, normal ceruloplasmin concentration may be seen in up to 5% of homozygotes who have the disease.[2] Paradoxically, normal levels, when present in homozygous Wilson's Disease patients, occur in a setting of active hepatocellular necrosis for reasons that are not clear, although increased plasma estrogen levels have been speculated to be responsible; in one reported case describing this phenomenon, the level became subnormal as the liver disease became less active.[4] In addition, estrogens of either exogenous (e.g., oral contraceptives) or endogenous (e.g., pregnancy) sources elevate ceruloplasmin concentrations normally and consequently may normalize a theretofore low level.[3] C. H. illustrates some of these points in that her serum ceruloplasmin concentration became subnormal six weeks post-partum. She was otherwise healthy, had no evidence of Kayser-Fleischer rings, but

had mild hypercupriuria. Normal liver histology and copper content excluded homozygous Wilson's Disease, although undoubtedly she is a heterozygote. By definition, both parents are necessarily heterozygotes as well, and in fact, A. H. does exhibit a low ceruloplasmin concentration.

Ultimate documentation of Wilson's Disease requires demonstration of elevated tissue copper levels. Visible Kayser-Fleischer rings fulfill this criterion and establish the diagnosis as was the situation with L. H. If these are not present, and slit lamp and gonioscopic examination have been performed, biopsy of the liver for both histology and quantitation of hepatic copper is indicated if warranted by the clinical and biochemical picture. Although normal adult copper levels are in the range of 20 to 50 $\mu$g per gm dry weight, levels of 250 $\mu$g per gm are felt to be critical for diagnosing Wilson's Disease.[2] Copper levels in excess of this can occasionally be seen in primary biliary cirrhosis, but differentiation of this from Wilson's Disease is easily accomplished on clinical grounds. Qualitative estimation of hepatic copper content with various stains is notoriously unreliable.[2]

Although excessive copper deposition in the liver, central nervous system, and other tissues is invariably present and somehow pathogenic in Wilson's Disease, the defect permitting this to occur has remained obscure. Both increased absorption and diminished biliary excretion, the main route for copper excretion normally, may be present,[2] and there is evidence for an abnormal hepatic protein with unusually high affinity for copper to account for the excessive liver stores.[7] Copper accumulation occurs to high levels prior to the appearance of structural abnormalities in the liver. Initially mitochondrial changes, visible only by electron microscopy, and fatty degeneration are seen.[8] Eventually disruption of hepatic architecture with hepatocellular necrosis occur followed by progressive scarring, giving rise to a non-specific picture of post-necrotic cirrhosis.[9] At no point is the liver histology in Wilson's Disease diagnostic. It is at the time of active hepatocellular necrosis, that redistribution of copper to other body sites is thought to occur. This concept is compatible with the observation that liver damage, though not always clinically apparent, always antedates neurological disease.

Both the propositus and W. H. exhibit some of the histologic changes described above. Undoubtedly a similar picture would have been seen in

*(Please turn to next page)*

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L. H. had a biopsy been done. Wilson himself recognized a point emphasized subsequently by others—the patchy nature of the liver disease with various stages present in the same liver. Indeed, the copper determinations from the same wedge of tissue in R. H. were quite different, neither being strikingly high. Had another sample been submitted, levels in excess of 250 $\mu$g per gm dry could likely have been found.

The approach then to the patient suspected of having Wilson's Disease should be to initially obtain a serum ceruloplasmin concentration. If this is normal, the patient has no evidence clinically of liver disease, and is not taking an estrogen preparation, the diagnosis can, for all practical purposes, be excluded. In addition, both urinary and serum copper determinations may give helpful information. If ceruloplasmin is low or if a falsely normal level is suspected, a careful search for Kayser-Fleischer rings should be initiated and if present confirm the diagnosis. If absent, liver biopsy will be necessary to either rule in or out Wilson's Disease; committing a patient to a lifelong course of therapy is indicated only after the diagnosis is unequivocably established. It should be noted that a search for the disease in children of Wilson's Disease patients should be deferred until the child is at least six months of age; low ceruloplasmin and high liver copper are normal neonatal findings.[5]

Once the diagnosis is established, therapy with penicillamine ($\beta,\beta$,-dimethyl cysteine) and a low copper diet (avoidance of nuts, mushrooms, shellfish, liver, and chocolate) can reverse many of the manifestations of the disease[10] and will prevent the appearance of the disease in asymptomatic homozygous patients.[11] The details of therapy have been dealt with elsewhere;[12] suffice it to say that effective cupriuresis and initiation of negative copper balance can be induced with relatively small doses as noted in Table I. Although copper is ubiquitous in foodstuffs, elimination of the above reduces copper intake to about 1 mg; therapeutic goals are thus attained if urinary excretion is kept in excess of this amount.

## SUMMARY

This report has dealt with the varied manifestations of the hepatic phase of Wilson's Disease as exemplified in part by this family; the means by which an unequivocal diagnosis can be established have been outlined. The availability of effective therapy not always at hand in other forms of progressive liver disease, emphasizes the importance of considering the diagnosis of Wilson's Disease in evaluating young patients with hepatic disorders.

## ACKNOWLEDGEMENTS

This work was supported by the National Institutes of Health Grant AM 5390.

The author wishes to thank Dr. Carl Vorhes, Sheldon, Iowa, and Dr. E. M. Juel, Atlantic, Iowa, for their help in evaluating the family described herein. In addition, the assistance of Dr. Irmin Sternlieb, Albert Einstein College of Medicine, Bronx, New York, was invaluable and greatly appreciated.

## REFERENCES

The references noted in this article may be obtained from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

## IOWA MEDICAL MISCELLANY

*(Continued from page 337)*

ently under contract with Farmland Industries. IMS representatives have met with AHP officials and have urged contact with county society presidents and secretaries before doing any screening. More info is available on request at IMS Hdqtrs.

**SCIENTIFIC PROGRAM . . .** IMS Program Committee will meet August 6 to undertake plans for the 1976 Scientific Session to be held April 6, 7 and 8 in Iowa City.

**VIETNAMESE PHYSICIANS . . .** Interest in securing Vietnamese refugee physicians has been expressed and pursued by several Iowa communities. Questions pertaining to licensure have been received by the State Board of Medical Examiners and the IMS.

**PEDIATRICS CONFERENCE . . .** The Annual Postgraduate Conference in Pediatrics at U. of I. will be September 25 and 26. Guest speaker will be William Oh, M.D. For information, contact J. A. Stehbens, Ph.D., Department of Pediatrics, University Hospitals, Iowa City 52242.

**RESEARCH FELLOWSHIPS . . .** The Kidney Foundation of Iowa is accepting applications for its 1976-77 research fellowships. Fellowships are to be served in Iowa and will be funded for $10,000 per year. Deadline for applying is 9/1/75. Info is available from Kidney Foundation Iowa, 3615 Douglas Avenue, Des Moines 50310.

# Illness Engendered by a Change of Clothes

DAVID GREEN, M.B., B.S. (Melb.)
Albany, New York

*Avoid the 'wooden' pajamas which may accompany hospital admission. So says the author in a review of the evolution of hospital care. He makes a plea for outpatient treatment whenever possible.*

SOME YEARS AGO, the title of a Broadway play announced that *Subways Are for Sleeping*. Since then, the social climate of New York City has changed. A new title might read *Subways Are for Mugging, Hiding, or Furtively Riding Without Glancing at One's Neighbors*. Regardless, it is true in the 1930's and 1940's one could sleep peacefully or study safely in the subways. I can personally testify to the fact as I was a student at City College and had to spend 90 minutes on the subway each day.

However, in the past when all we had to worry about was a depression, starvation and the timing of the onset of World War II, it was a fact that both subways and hospitals were for sleeping.

It is dangerous, I know, to lean too hard upon one's childhood memory. The recollections fall on both sides of the median of truth. They consist of either over-idealization in which everything seemed better and more orderly or of hateful glimpses of a past best left unremembered. I remember my occasional hospital visits in those days to see relatives, and those memories are similar to silent movies compared to the noise-filled corridors I now walk. These relatively few early visits to a hospital filled me with respect for their cathedral-like atmosphere, their serenity and cleanliness. I didn't think anyone, either staff or patient, spoke above a whisper. The rooms seemed quiet, lonely, austere and very orderly. There were boxes on the wall where numbers lighted now and then, presumably for the staff to see and answer. In my own teaching hospital 22 years ago, I remember hearing an operator's voice only once announce a ward emergency and this instance called down a storm of disapproval and disdain on all involved, since it indicated a loss of nerve and clinical equanimity.

Dr. Green is a clinical associate professor in Department of Neurology at Albany Medical College, Albany, New York. This paper was presented at 1974 annual meeting of New York State Medical Society. Dr. Green was on the resident and full-time staff at the University of Iowa College of Medicine from 1954 to 1963.

## TODAY IS DIFFERENT

Today the opposite of all this is true. A walk down a hospital corridor is hardly a stroll down a cathedral aisle. If anything, it is similar to the gangway of a light cruiser with a collision drill or general quarters in process. Noise prevails, deafens, permeates and dominates. Carts with loose and squeaky joints rattle by. There is a continuing tumult of food trays and bottles falling to the floor. Air-vacuum messenger systems hiss and explode like a small caliber cannon. Above all this is the dismal din of operators' voices (some of them using an irritating imitation of stage English) announcing everything from a misparked car outside to an emergency in the intensive care unit, with specific details as to the department personnel needed and names of physicians. This allows relatives in the waiting room to quickly identify exactly who has fallen over the medical brink. As if that were not enough, seconds later one can hear the charging gallop of heavy-footed residents sounding much like Ionesco's Rhinoceri. As the house officers converge on the room of the near-doomed, a second tableau is unveiled. This consists of residents tugging and pushing a Juggernaut-like cart of technical sophistication with the same intensity as their Hindu counterparts on the streets of Madras. One must be agile and get out of the way quickly. I have seen innocent inanimate objects, such as a telephone, destroyed as the cart of succor rolled by.

In all this can the average patient who is merely ill get any rest? The answer is no, but this answer is made inaudible by the noise enveloping him. Sleep is out of the question. Rest is infrequent. Fear and terror of what might happen next probably preoccupy the patient's mind.

### TAKE A CHANCE

All of us take a great chance when we enroll as a hospital patient. If one is unlucky to come in the same day as another with the same name, a comedy or tragedy of errors often ensues. God help the mythical (and not so mythical) Walter Mitty with bronchiogenic carcinoma and metastatic brain disease and the Samuel Mitty with low back pain if they both have the misfortune of landing on the same ward. One could bet a plugged nickel against one's percussion hammer that the man with low back pain will be put on a cart headed for the bronchoscopy room unless you happen to be on the ward and physically undo the straps holding him down. I speak from personal experience on this. A large error such as this is not uncommon. Small errors such as irrelevant borderline obscurities or frank outlandish errors in biochemical laboratory studies are as common as mosquitoes in August. In fact, some in-patient charts really deserve publication as Acta Artifacta. Once these errors appear in the hospital chart, they incite a flurry of mindless, repetitious activity which often results in a further immense number of irrelevancies and a slightly anemic patient.

Neurology is a pretty subject and is one of the last strongholds of clinical medicine in which an intelligent analysis of history and physical signs can lead to an equally intelligent and accurate diagnosis. A clinician worth his salt should be able to out-point and out-predict any laboratory in any hospital. The provisional clinical diagnosis in seasoned hands should be equal to the final diagnosis regardless of the sophistication and volume of laboratory work expended. The better the clinician, the less laboratory work he orders.

That is fine when the clinician is looking after an outpatient. However, once that self-same so-called seasoned, competent, intelligent physician brings a patient in to the hospital, it seems he is transformed into something wild and strange. Perhaps, he might well be compared to one of the Ionesco Rhinoceri mentioned before. He seems transformed into a timid, conforming, feckless and witless imitator or that lowest common denominator of imbecility, the house officer who doesn't know when to come in out of the rain.

### LABORATORY MADNESS

All clinical sense seems to fly out of the window. I am as guilty of this as everyone else, and the only way I know to control this disease is to admit patients very sparingly. Once in the hospital, the patient has the laboratory book thrown at his head (at least in neurology) both literally and figuratively. Caution and a sense of proportion with respect to expense seem to be abandoned. One chases the will-o'-the-wisp in terms of laboratory data with the appetite of a maddened lotus eater. Neither sense nor mercy is shown. There are moments when only the development of a grave laboratory induced anemia, the threat of the patient to sign himself out, or the screams of the anguished relatives can halt the inexorable march of the unthinking student and house officer.

Time and expense no longer matter as long as that all-devouring Moloch, the teaching service, make demands. We over-admit, over-investigate, over-pursue and over-extend the patient's stay. The older clinicians are at a disadvantage once this fearful sequence begins because none of us want to appear old-fashioned, fussy or crabby. Nor do we want to develop the reputation that we wish to cabin or stunt the growing minds of our pupils. There is no more hope to limiting useless studies once they are written and begun than trying to grasp a stream of running water or stop a focal fit by reading a stanza of the Faerie Queene to the patient.

The longer the patient remains in hospital, the more likely errors of judgment are possible and the more likely that someone (during one of the many interminable and inconclusive clinical conferences) will think of the one brilliant study that hasn't been done but which cannot be scheduled until next Monday.

The rates our patients pay for their hospital rooms are usually higher than any daily hotel rate on the Riviera in season. And how little they obtain at times for this rent. Inadequate and amateurish clinical attack, coupled to inordinate delay and complimented by a cuisine similar to that in Sing-Sing on a weekday is often the rule. The simple issue of a consultation in hospital has been known to make grown men weep. Phone call messages to an answering service are misplaced, misinterpreted or never delivered. The

consultants arrive late, resentful or given to hastiness. The same consultation in the office is more leisurely, private and satisfying for everyone. If not any of these, it is at least cheaper in that one doesn't have to wait two or three days at $75 per day for the pleasure of the doctor's non-arrival. There are times when the conduct of everyone in hospital, except for the patient, might adequately be described as a performance more worthy of a Major Bowles' amateur hour, were it not for the painful and sometimes mortal consequences.

Finally, there isn't a worse place in the world for an elderly person than a hospital. Here, every noise is new and difficult to understand. Every face belongs to a stranger. Every room is an unknown world and every night is a hideous experience of darkness and fear. At night our wards are truly caverns of cries and whispers.

The elderly patient is endlessly condescended to and treated as a child. The patient who moves about too freely is given tranquilizing drugs and restrained so relatives are astounded when they visit the patient for the first time. When last seen in the admissions office, the patient was his own, perhaps mumbling, shuffling self and now is converted into a somnolent, handcuffed, inept idiot. All this reflects the attitude of the nursing and house staff and implies that a sleepy patient is better than an awake one. Unfortunately, the attending staff do not or cannot stop this, though the best way would be to avoid admission if at all possible.

## OUTPATIENT EMPHASIS

The elderly regress and fall apart on the wards. They should, if possible, be kept out of the hospital and investigated as outpatients. Sometimes the fault concerning admission is not ours but rather that of insistent and ultimately foolish relatives who think the word hospital still carries with it its old connotation of hospitality. Rather than this, there is more coldness and impersonality (often engendered by seemingly endless changes of personnel) than one would care to admit. We all know good wards and these inevitably depend on two or three devoted nurses. When these nurses leave, the ward quickly becomes a routine place.

The number of tumbles out of bed by the elderly patients cause one to think (if statistics are reviewed) that we are fielding a low hurdle team rather than sick individuals. The bedrails seem to play the role that Everest played for Hillary. The basic theme is mumbling confusion in the dark and then up and over, using the light in the toilet as an aid to navigation. The results are bruises, head injuries, fractured hips and suspicions about subdural hematomas, all of which imply more laboratory work, time spent in hospital and loss of money. If I can make one plea it is that we should make every effort to investigate patients with dementia on an out-patient basis except when our hand is strongly forced.

Will Rogers said, "All I know is what I read in the papers." I don't know what he would have said in the post-Watergate period of mendacity in government and timidity in the press. But there is one thing one could learn from the press today concerning medicine.

## UTILIZATION

The government is at every level letting out a continuous scream of pain and dismay at the inordinate tendency of physicians to admit patients to hospital. The expense is fierce and bound to increase. The advantage of out-patient investigation and care of patients is obvious at every level.

Out-patient care of a patient is less expensive than admission to hospital. It forces the clinician to be more economical and more astute clinically. It saves time and, perhaps, most important of all, it is usually more comfortable for the patient who is left in his home and often at work, able to make a living. There is little sense in paying an exorbitant and intolerable rent for a hospital room, sometimes full of dismal and frightening sights and noise, if we can stay at home and accomplish the same or better.

I don't deprecate the hospital bed for some patients. There is a time and place for this in the critically ill, in those who cannot walk, in the abandoned, in those who cannot fend for themselves and in those patients where a serious question of progressive incapacitating illness exists. One cannot lay down rules of clinical conduct except to say that one should be considerate and cautious. Yet, in the long run, a clinician is judged on the number of patients he has kept out of hospital rather than on the number of patients he has admitted.

The colloquial phrase in Spanish for coffin (pijama de madera) freely translated into English is wooden pajamas. I have attempted to illustrate that entering a hospital and exchanging

one's clothes for hospital pajamas implies great risk (both physical and financial) for the patient. That change of clothes is at times the most fateful act a patient can commit and, unfortunately, there are times when the hospital pajamas metamorphose into wooden pajamas unnecessarily. There is enough tragedy in life and in illness without our witless compounding of it by error.

We must guard our patients against coming out of hospital in wooden pajamas and the best way I know to prevent this is to avoid unnecessary admissions to hospitals.

# Cancer Case-Finding in Gross Anatomy To Stimulate Student Interest

S. A. TERMAN, Ph.D., W. K. METCALF, M.D., N. F. METCALF, M.B.B.S., and D. MILLER, B.A.

*Interest in anatomy was heightened for Iowa Medical students through an opportunity to identify and investigate suspicious lesions on cadaver patients. Hope is the project will give the students a cancer-detection frame of mind.*

THE VALUE of introducing clinical relevance into the basic sciences is being recognized increasingly. At the University of Iowa, N. F. Metcalf[1] initiated a Pathology Project in Freshman Gross Anatomy in 1970. With support from an institutional clinical cancer training grant, this activity was expanded considerably. The purpose of the cancer case-finding project was to stimulate medical student interest in cancer as a disease at an early stage in the education program. It was hoped also that "first patient" treatment of the cadaver would increase student involvement in the basic science studies. Most important was the early effort to develop a "cancer-detection" frame of mind in the student by raising the index of suspicion on the "first patient."

The project reported here was supported in part by National Cancer Institute clinical cancer training grant number T12 CA Ca08084, and the University of Iowa Department of Anatomy. This article is based on a paper read by Dr. H. B. Latourette at the seventh annual meeting of The American Association for Cancer Education, November 9, 1973 in Honolulu, Hawaii.

Dr. Terman was assistant in cancer education, University of Iowa, College of Medicine and is now Fellow, Clinical Pharmacology, Eli Lilly and Company. Dr. W. K. Metcalf was a professor of anatomy, U. of Iowa, and is now chairman of anatomy, U. of Nebraska. Dr. N. F. Metcalf was an instructor of anatomy, U. of Iowa, and is now assistant professor of anatomy, U. of Nebraska. Mr. Miller was a pathology extern, and is now a U. of Iowa medical student.

## PROJECT DESIGN

Freshman students were encouraged (1) to identify any suspicious lesions, (2) to have macroscopic photographs taken, and (3) to send specimens with a completed pathology request form for microscopic preparation and tissue diagnosis. Fortunately, a number of the anatomy instructors were both experienced in pathology and available in the lab to assist in this process. Copies of the death certificate and a brief medical history were available for each cadaver so students could write to the certifying physician, where appropriate, for further information. The pathology reports and the supporting slides were returned to the student for examination, and served as the basis for a full "autopsy" report to be sent to the local physician.

The program included the following aspects:

(1) Completed cases with histories, reports, macrophotographs, microphotographs and microscope demonstrations were displayed in a room adjoining the anatomy lab; (2) a workshop was held to organize and to collate the material; (3) an optional lecture was given summarizing the findings of the whole class, and (4) the materials were preserved for casual review in a carousel slide program with text, macro- and microphotographs.

## EVALUATION

Evaluation of the project was attempted 1) by counting the number of students participating in the various activities, 2) by a questionnaire, and 3) by student comments. Although some form of

*(Please turn to page 363)*

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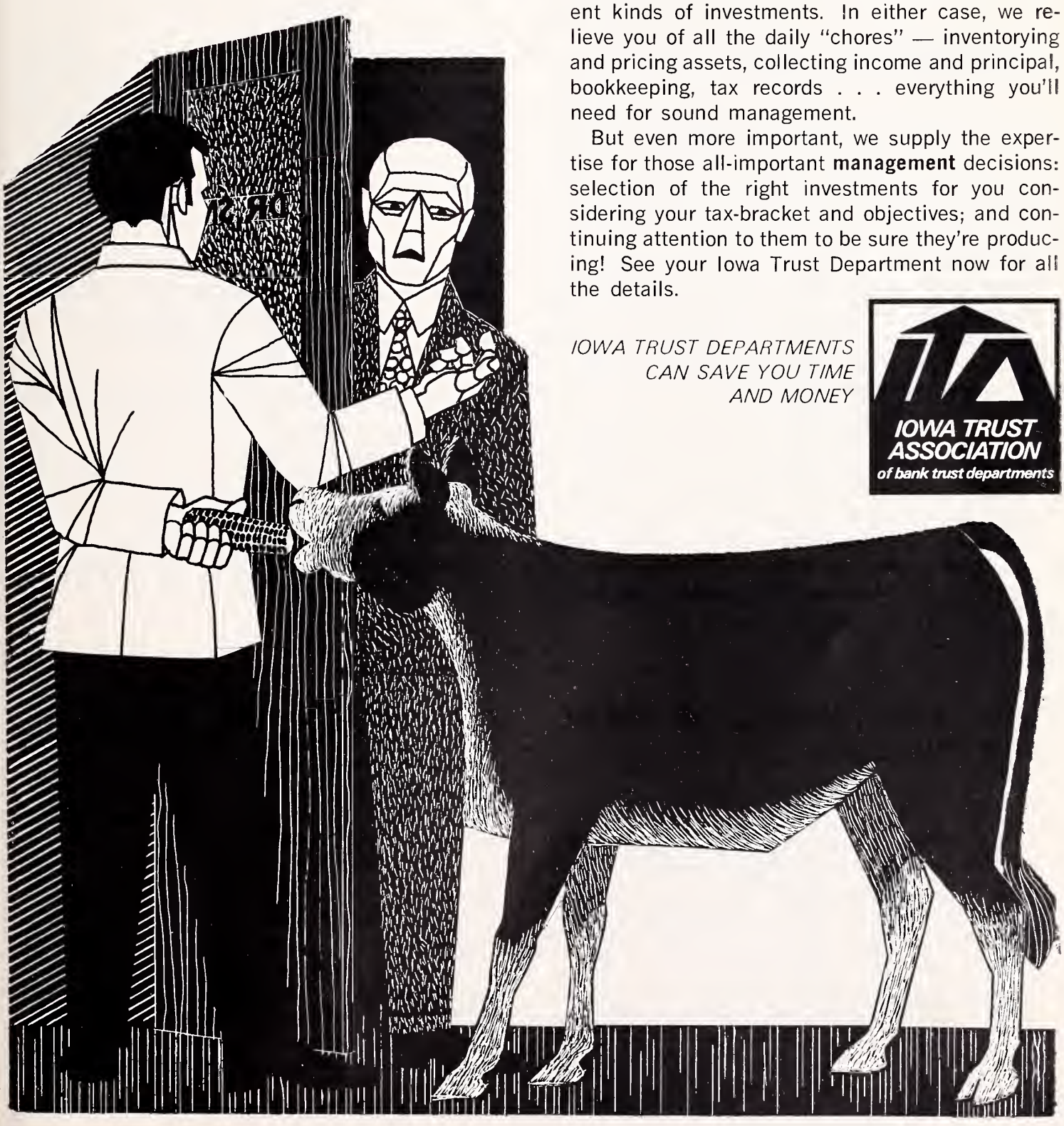

# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## OUR READING HABITS

Many physicians, along with professional people in other disciplines, lead a shallow life when it comes to reading. Professional journals, the daily newspaper, and perhaps a news magazine, are often the total reading adventure. Our professional journals have become so specialized they tend consequently to produce an even more narrow view; another unfortunate situation. The time-worn excuse easily becomes, "not enough time." We hope this journal presents enough variety to entice Iowa physician readers.

A change in our journal has gone mostly unnoticed. We no longer have a section devoted to book reviews. In years past we received books from various publishers for review purposes. Voluntary reviews were sought from interested physicians and sometimes were forthcoming; other times we heard nothing after sending the new book to our reviewer. The numbers of books have diminished, various publishers have discontinued sending books and readership of that section of the journal obviously was limited. Furthermore, the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION provides an excellent book review section. We urge you to use that source of information about new medical publications.

We urge you further not to restrict your reading to medical publications only. It is obvious when visiting foreign countries that Americans are inadequate in their language skills. Many people in other countries speak and/or read several languages, while many of our high school graduates have a difficult time mastering the English language. German was commonly spoken in my home when I was a child, but I cannot use the language. I wish I knew how. Perhaps I ought to get a book and relearn German. Spanish would be valuable to know, too. There are other learning experiences to be gained from books. But I have a problem—"not enough time."—M.E.A.

## AMA PHYSICIANS' RECOGNITION AWARD

It's time to consider your qualifications for the AMA Physicians' Recognition Award. These awards recognize participation in continuing medical education and cover a three-year period dating from July 1. Thus, if your last receipt of this recognition was three years ago, it is time to submit your application for 1975. A minimum of 150 CME credit hours must be earned in a three-year period to qualify. These credit hours must be distributed among various categories as stipulated by the AMA.

Category 1 credits are earned from accredited sponsorship activities. Included are grand rounds, teaching rounds, departmental scientific meetings, seminars, workshops, accredited courses as well as scientific sessions of medical societies. At least 60 hours (with no limit) must be accumulated in this category.

Category 2 credit is limited to 45 hours and may be earned in nonaccredited CME areas.

Category 3 also has a 45-hour limit and con-

sists of medical teaching (medical students, physicians, and allied health professional personnel).

Category 4 is restricted to 40 hours and affords credit for papers, publications, presentations, books, and exhibits.

Category 5 is a composite of nonsupervised individual efforts in continuing medical education. Self-learning, consultation, patient care review, self-assessment, and preparation for specialty boards are included here. Each of the areas carries a 22-hour limit, and the entire category has a limit of 45 hours.

Finally, Category 6, with a 45-hour credit limit, consists of other meritorious learning experiences not included in the other categories. Medical research is represented in this area. The applicant must document certain data—what, who, how done and evaluated, who supervised, etc.

Your application papers, obtained from the AMA Department of Continuing Medical Education, should be returned with the $5 fee. It is not so much the certificate you receive as it is the documentation you have of your continuing education efforts. Let us face the reality of peer review, not only in hospitals but in our offices as well. Early efforts to prove one's desire to "keep up" may lessen difficulty later in the mechanics of continuing education. Then, in preparation for the ensuing years, the wisdom of keeping an ongoing log of your education efforts may pay off in terms of making note of dates, places, sponsorship, context of the education experience, and the hours devoted to each situation. If you keep such a log with divisions in the various categories, a simple compilation is quickly accomplished at the end of the 3 years.—M.E.A.

## CANCER CASE-FINDING IN GROSS ANATOMY

*(Continued from page 360)*

cancer was present in only 8 of 45 cadavers, 75% of the class of 165 students encountered "suspicious" lesions in the course of their dissection and, after discussion with an instructor, 70% of these lesions were photographed and submitted for microscopic tissue diagnosis. Seventy per cent of the students viewed the microscope displays, and almost half attended the optional lecture. The workshop was not well attended.

The questionnaire results merit interpretation in light of the 18% incidence of cancer in the cadavers. (Also, several documentations of malignant disease were made late in the course of the dissection.) Nevertheless, 48% of the students felt the project had a positive effect in increasing their interest in cancer as a disease, compared to a semester of dissection without this project, and one-third felt the project increased their interest in the study of normal structures. As an indication of their continuing interest, nearly 40% stated they would review the carousel slide program on the project. We feel particularly encouraged that 90% felt the project should be continued. One of the more constant comments made by students was the emphasis on returning microscopic slides and tissue diagnosis in a short time, in order to maintain student interest. The students also suggested that more lecture time be devoted at the beginning of the course to orientation on cancer as a disease, and on the overall plan of the project itself. An important goal of the project was to create a "cancer-detection" frame of mind in the freshman medical student, in the hope this would continue to develop and pervade his career.

### CONCLUSION

In light of our experience and based on the questionnaire results, we concluded the following modifications are indicated: The carousel slide presentation of the preceding year's project should be used to introduce and to explain the program. An introductory lecture on the nature of cancer as a disease should be provided. And, perhaps most importantly, the time between submission of material for sectioning and tissue diagnosis and receipt of the slides and report should be as brief as possible to maintain student interest. With these relatively minor modifications we believe a highly successful learning experience will result.

### REFERENCE

1. Metcalf, N. F.: Pathology in gross lab: motivation or correlation? *Anat. Rec.*, **172**:440, 1972.

# Morbidity Report for June, 1975

| Disease | June 1975 | 1975 to Date | 1974 to Date | Most June Cases Reported From These Counties |
|---|---|---|---|---|
| Amebiasis | 1 | 11 | 14 | Henry |
| Chickenpox | 176 | 6596 | 6113 | Clinton, Dubuque, Polk, Webster |
| Conjunctivitis | 44 | 842 | 518 | Clinton, Johnson, Linn |
| Encephalitis | | | | |
| Viral | 1 | 2 | 11 | Poweshiek |
| Type unspec. | 1 | 2 | 13 | Clinton |
| Gastrointestinal virus inf. | 89 | 14652 | 5495 | Cerro Gordo, Clinton, Humboldt, Johnson |
| Giardiasis | 1 | 8 | 23 | Henry |
| Hepatitis, A (Infectious) | 9 | 92 | 176 | Linn, Polk |
| Hepatitis, B (Serum) | 6 | 50 | 53 | Dubuque, Linn, Polk, Wapello |
| Hepatitis, type unspecified | 3 | 21 | 20 | Buchanan, Taylor, Woodbury |
| Hand, Foot & Mouth Disease | 2 | 5 | | Union |
| Impetigo | 5 | 325 | 194 | Cerro Gordo, Clinton, Hancock, Story |
| Infectious mononucleosis | 34 | 785 | 589 | Johnson, Monroe, Scott |
| Influenza-like illness | 145 | 36119 | 89333 | Fayette, Polk, Worth |
| Meningitis | | | | |
| Bacterial | 1 | 7 | | Montgomery |
| Cryptococcal | 1 | 1 | | Black Hawk |
| *H. influenza* | 3 | 10 | | Appanoose, Muscatine, Scott |
| Streptococcal | 1 | 2 | | Muscatine |
| *E. Coli* | 1 | 1 | | Jefferson |
| *D. pneumoniae* | 1 | 1 | | O'Brien |
| Type unspecified | 2 | 23 | 17 | Iowa, Muscatine |
| Mumps | 70 | 982 | 1606 | Muscatine, Polk |
| Pediculosis | 10 | 200 | 245 | Cerro Gordo, Linn, Marshall |
| Pinworms | 1 | 24 | 30 | Polk |
| Pneumonia | 66 | 687 | 556 | Clinton, Lee, Linn, Scott, Washington |
| Rabies in Animals | 19 | 60 | 72 | Scattered |
| Rheumatic fever | 1 | 10 | | Ida |
| Ringworm, body | 2 | 171 | 97 | Franklin, Jefferson |
| Rocky Mountain Spotted Fever | 1 | 3 | 1 | Lucas |
| Rubella congenital syndrome | 2 | 2 | | Johnson, Wapello |
| Rubella | 1 | 19 | | Dubuque |
| Rubeola | 58 | 461 | 103 | Dubuque, Greene, Polk |
| Salmonellosis | 15 | 86 | 83 | Scattered |
| Scabies | 22 | 247 | 52 | Dubuque, Johnson, Polk |
| Schistosomiasis | 2 | 2 | | Boone |
| Shigellosis | 5 | 36 | 97 | Dubuque, Polk, Poweshiek |
| Streptococcal infections | 414 | 6488 | 6647 | Jackson, Johnson, Marshall, Polk, Scott |
| Trichuriasis | 1 | 2 | | Polk |
| Tuberculosis, total ill | 9 | 65 | | Appanoose, Bremer, Linn, Polk, Warren |
| Tuberculosis, bact. pos. | 3 | 28 | | Appanoose, Black Hawk, Polk |
| Venereal diseases: | | | | |
| Gonorrhea | 624 | 3198 | 2987 | Black Hawk, Clinton, Linn, Polk, Scott |
| Syphilis | 27 | 157 | 213 | Scattered |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | |
|---|---|---|---|
| Cytomegalovirus | 3 | Herpes Simplex | 9 |
| Eaton's agent | 1 | Herpes zoster | 1 |

## OPHTHALMIA PROPHYLACTIC

The following new rule pertaining to ophthalmia prophylactics for newborn infant eyes has been proposed by the Iowa State Department of Health:

*Treatment of infant eyes. The Iowa State Department of Health approves only a one percent solution of silver nitrate from single-dose unopened wax ampules in each conjunctival sac as an ophthalmia prophylactic for newborn infants' eyes. Silver nitrate, once applied, should not be followed by a normal saline flush.*

Interested persons may participate in this rule-making by submitting written comments to Theodore D. Scurletis, M.D., Medical Director, Maternal and Child Health Section, Personal and Family Health Division, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319. Comments must be received before September 1 to be considered.

# Medical Assistants

by TENORA MEYER, CMA

## INSTALLS MONTANA OFFICERS

Jeanne Green, CMA, Davenport, National Membership Chairman, participated in the formal establishment of the Montana State Society, AAMA, May 17, by installing the new officers. Mrs. Dee Walker, of Billings, Montana, is the organization's president.

## DR. KLEINERT TO SPEAK

The 19th annual AAMA convention will be October 5-10, at Galt House in Louisville, Kentucky, on the bank of the Ohio River. "Fast Track to Education" is the theme. An advance registration package (with special rates) is available until August 15.

The world-renowned hand surgeon, Harold E. Kleinert, M.D., will be a guest speaker. Dr. Kleinert is famous for the microsurgery he performs and teaches. He first started reimplantation of the digits onto the hand and the performing of small blood vessel surgery. He is one of the first physicians in the Western World to perform total joint replacements in the hands of arthritic patients.

## MASON CITY SEMINAR

The Mason City Chapter of Medical Assistants held a successful May 4 seminar. Among the topics presented were "Resources Available to Patient" by Muriel Peterson, social worker, Memorial Hospital; "Office Sterilization Techniques" by Joan Prickett, R.N.; "Office Etiquette" by Joann James, immediate past president, AAMA, State of Iowa; "Small Claims Court and New Collection Laws" by Ray Lichty, Mason City Credit Bureau; "Laboratory Orientation" by Phyllis Kavars, laboratory technician, and "When X-rays Are Ordered" by Glenn Borchardt, X-ray technologist.

## LABORATORY SPECIMENS

Robert Ketelaar, M.D., Davenport Medical Laboratory, spoke recently to the Davenport Chapter of Medical Assistants. He emphasized three main problems in the laboratory area:

(1) Improperly labeled specimens. Each label should contain first name, last name, middle initial, age, date specimen obtained, patient's doctor and source of specimen.

(2) Patients should be sent to the outpatient laboratory in a fasting state for most tests, especially for a fasting blood sugar, cholesterol, triglycerides, lipoprotein electrophoresis. It should be explained to the patient why he is being sent to the laboratory and how long it will take to perform, for instance, a glucose tolerance test.

(3) Urine specimens should not be brought in unclean receptacles. Shampoo, for instance, or other detergent can never be washed out of a container and should not be used.

## PROFILE OF AAMA MEMBERSHIP

AAMA members are younger in eastern areas than those in western regions; midwestern medical assistants tend to stay with one employer longer than in other regions of the country; medical assistants in the southeast work more hours per week. These findings are from a recent AAMA survey which involved analysis of 6,387 questionnaires. Slightly over 50% of the responding medical assistants work in one-physician offices; 15% work in two-physician offices; and 21% work in practices of three or more physicians. The length of service is impressive: 27% had between 11 and 20 years experience; 11% had between 21 and 30 years; while 55% had 10 years or less. Regional variations were not great, although respondents from the northeast and northwest had slightly less experience than those from the midwest and southwest.

# About IOWA Physicians

**Dr. Paul L. Wolpert,** Onawa, received the Alumni Achievement Citation from Creighton University at spring commencement ceremonies in Omaha. Dr. Wolpert is a 1936 graduate of the Creighton School of Medicine. All nine of Dr. and Mrs. Wolpert's children either have graduated from or are attending Creighton University. . . . **Dr. Helen Barton,** Independence, has retired after 20 years on the medical staff at the Mental Health Institute. . . . **Dr. Rosalie Neligh,** Council Bluffs, is the first woman to serve on the State Board of Medical Examiners. Other physicians appointed by Governor Ray are—**Dr. Hal Hirleman,** Cedar Rapids; **Dr. J. M. Rhodes, Sr.,** Pocahontas; **Dr. C. L. Beye,** Sioux City and **Dr. H. G. Ellis,** Des Moines. . . . **Dr. M. Neil Williams** and son, Thomas, Cedar Falls, traveled in May to the Dominican Republic to participate in Medical Group Mission Program of Christian Medical Society. The trip to the Dominican was the second for Dr. Williams and his son. . . . **Dr. Richard L. Vaught,** Sioux City urologist, has received the AMA Physician's Recognition Award. . . . **Dr. F. S. Larsen** has retired from medical practice in Fort Dodge and will join Department of Student Health at U. of I. College of Medicine.

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**Dr. David Moershel,** Cedar Rapids, received his M.D. degree at U. of I. College of Medicine this spring. In doing so, he became the fourth generation member of his family to be graduated from the U. of I. College of Medicine. His father, **Dr. William Moershel** was graduated in 1943; his grandfather, **Henry G.,** in 1917; and his great-grandfather, **William,** in 1888. Dr. William Moershel practices psychiatry in Cedar Rapids. Dr. David Moershel plans to begin a pediatric residency at Children's Medical Center, Parkland Hospital, Dallas, Texas. . . . **Dr. Roy Pitkin,** professor of obstetrics and gynecology at U. of I. College of Medicine, was a visiting preceptor with **Dr. James D. Kimball** in Osceola in May. U. of I. faculty members have this type of preceptorship program available which takes away from the University setting for brief exposure to community practice. . . . **Dr. James L. Knott,** Council Bluffs, has been elected president of Iowa Clinical Society of Internal Medicine at group's annual meeting. . . . **Dr. Ramon A. Yaldua** and his wife, **Dr. Cristina Crespo-Yaldua** have closed their medical practices in Forest City. Dr. Cristina Crespo-Yaldua plans to practice obstetrics and gynecology in Casper, Wyoming, while Dr. Yaldua serves two years in the Navy to expedite the acquisition of U. S. citizenship. Following his military service, Dr. Yaldua will join his wife and family in Casper, Wyoming. . . . **Dr. Campbell F. Watts,** Cedar Rapids, has been named president of the Iowa Clinical Surgical Society and **Dr. Emmett Mathiasen,** Council Bluffs, is new president-elect.

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**Dr. Mark Steine,** Osage, and **Dr. R. G. Barrett,** Rockford, were honored recently by the Mayo Medical School for their service as preceptors in the school's family practice program. . . . **Dr. Peder D. Madsen,** Newton, was guest speaker at recent meeting of Newton Kiwanis Club. Dr. Madsen discussed medical practice in Sweden under a socialist government. . . . **Dr. Carl Aschoff,** Cedar Rapids, is new president of Linn County Medical Society. Other officers elected at the society's annual meeting are—**Dr. James Stiles,** president-elect; **Dr. Richard Sedlacek,** vice president; and **Dr. Richard Quetsch,** secretary-treasurer. All are Cedar Rapids physicians. . . . **Dr. E. M. Victorine,** Cedar Rapids, was presented two plaques, one from the Sisters of Mercy and one from the nurses at Mercy Hospital, at an open house in his honor. Dr. Victorine, an IMS life member, began his medical career in

1915 and prior to his retirement had practiced medicine in Cedar Rapids for 51 years. . . . **Dr. Mary Louise Gannon,** Spencer, was recently certified by American Board of Urology. . . . **Dr. David B. MacMillan** has joined the Rohlf Memorial Clinic in Waverly. A native of Mason City, Dr. MacMillan received the M.D. degree at U. of I. College of Medicine in 1969; interned at Tripler General Hospital in Honolulu; and served his residency at Brooke General Hospital in San Antonio, Texas.

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**Dr. William B. McTaggart,** Fort Dodge physician since 1944, retired from active practice in July. A 1928 graduate of Creighton University Medical School, Dr. McTaggart interned at St. Mary's Hospital in Hoboken, New Jersey and practiced medicine in New Jersey and New York prior to locating in Iowa in 1932. . . . **Dr. Gerald Miller,** former Clarinda surgeon, has re-located in Shenandoah. . . . **Dr. L. A. Gaukel,** Onawa, was recently presented a plaque commemorating his 42 years of medical service in the Onawa area. . . . At the June meeting of the Wright County Medical Society, **Dr. William C. McCormack,** Ames, spoke on the neonatology intensive care unit at Mary Greeley Hospital. Registered nurses and physicians from several surrounding counties attended the meeting.

## DEATHS

**Dr. C. R. Harken,** 90, died at his home in Osceola on May 8. Dr. Harken received the M.D. degree at U. of I. College of Medicine and began his private practice of medicine in Osceola in 1907. A life member of the Iowa Medical Society, he retired from active practice in 1964.

**Dr. Paul Van Metre,** 96, Rockwell City physician for over 50 years, died in Fort Dodge on May 16. Dr. Van Metre received the M.D. degree at U. of I. College of Medicine in 1910. He was a life member of the Iowa Medical Society.

**Dr. Robert J. Dawson,** 45, Estherville, died June 11 in an automobile accident near Fort Dodge. A graduate of U. of I. College of Medicine, he served his internship at Broadlawns Polk County Hospital in Des Moines and practiced in Graettinger before locating in Estherville in 1964. Dr. Dawson was vice-president of the Iowa Foundation for Medical Care.

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Burroughs Wellcome Co. ..... 347

Flint Laboratories ..... 342A, B

Iowa Trust Association ..... 361

Lilly, Eli, & Co. ..... 333

Medical Protective Company ..... 367

Michigan Department of Mental Health ..... 345

Pharmaceutical Manufacturers Association .... 352D, 353

Prouty Company ..... 355

Roche Laboratories ..... 334-335, 371, 372

Roerig, J. B., & Co. ..... 352C

Searle, G .D., & Co. ..... 352, 352A

Smith, Kline and French Laboratories ..... 352B

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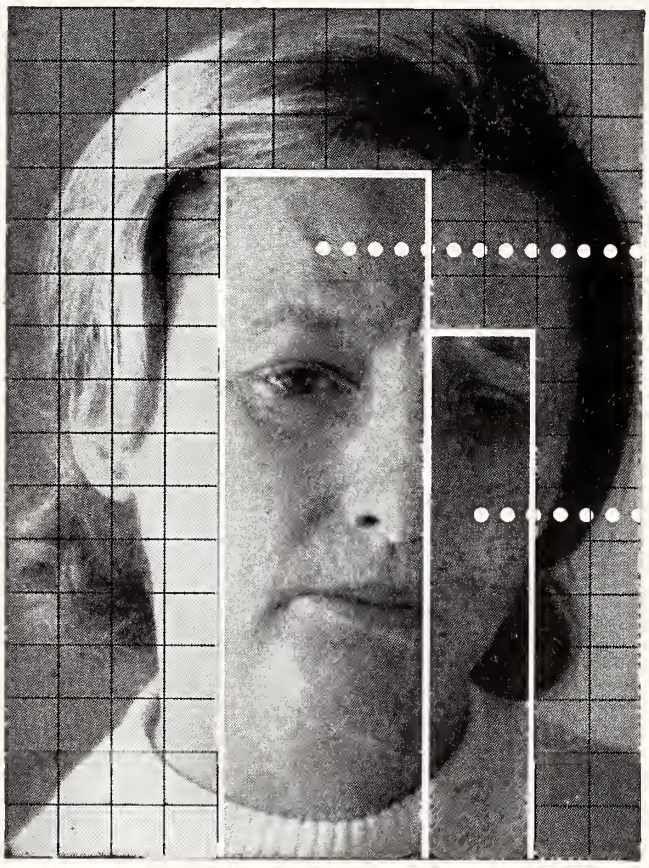


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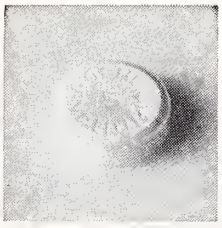

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# President's Page

September usually means the end of vacations, the start of school and a return to what's often called *a normal routine.*

While the summer pace at the Iowa Medical Society has been steady, fall means increased acceleration. A 1975-76 schedule of events will include seminars for new members, county society officers, legislative contact men, specialty organization officers—plus regular meetings of the Board, Council and House of Delegates—plus numerous committee meetings—plus the scientific session next April 6, 7 and 8.

The areas of interest and concern are well known. Matters pertaining to continuing medical education are being pursued by the Committee on Medical Education and Hospitals under the chairmanship of C. R. Aschoff, M.D. The professional liability situation remains the priority concern of the Medico-Legal and Legislative Committees, headed by C. H. Denser, Jr., M.D., and D. C. Young, M.D., respectively. Health planning developments are being followed by the Committee on Delivery of Health Services, chaired by M. E. Olsen, M.D.

These are examples of committee activity within the Society's organizational framework. Policies emanate from these components and come in the form of recommendations to the House of Delegates and Executive Council. The President and the Board of Trustees seek to implement the policies thus established.

The IMS has a challenge and through the efforts of all, these challenges will be met.

Sincerely,

V. L. Schlaser MD

*V. L. Schlaser, President*

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# IOWA Medical Miscellany

**STUDY GROUP NAMED . . .** Ten Iowa legislators were named in late July to the General Assembly's interim study committee on medical liability. This committee must submit a report to the 1976 Assembly. Appointees are: Senate—William Palmer, Des Moines; Robert Carr, Dubuque; Warren Curtis, Cherokee; Willard Hansen, Cedar Falls; Lowell Junkins, Montrose. House—Horace Daggett, Kent; Maurice Hennessey, Ryan; Robert Kreamer, Des Moines; Arthur Small, Iowa City; Craig Walter, Council Bluffs. IMS offer to provide support and expertise has been extended. First meeting is set for September 9.

**JUA FORMED . . .** Formalization of the Joint Underwriting Association occurred in late July with approval of corporate language by JUA governing board. Insurance Commissioner Huff has authority to set the JUA into motion. Hope exists however the private market will provide sufficient coverage to avoid need for the JUA. C. H. Denser, Jr., M.D., represents IMS as one of three providers on the 11-member JUA board; others are from insurance companies.

**CLAIMS-MADE . . .** St. Paul has advised a one-time purchase of the reporting endorsement or "tail" will be possible under its new claims-made form of liability coverage. The three-year option will remain available.

**EQUITY ADJUSTMENT . . .** IMS Executive Council has supported implementation of a Blue Shield proposal to aid physicians facing exorbitant liability insurance premiums. Allowance for an equity adjustment would be granted to a physician whose liability premiums increased 300% or more during the last two years.

**ASSESSMENT . . .** IMS Board of Trustees has determined it will defer implementation of authority given by the House of Delegates to assess members up to $100 to fund further professional liability activities.

**HEALTH SYSTEMS AGENCY . . .** HSA interim board has recommended the state's health service area (which now includes 90 Iowa counties) have 5 sub-areas. This concept is being assessed by the 13 existing area planning councils. Late August session of interim board permitted further consideration of HSA organizational and procedural requirements.

**STATE PLAN . . .** A state comprehensive health plan for Iowa has been completed by the Office of Comprehensive Health Planning and will be available in September. IMS expects to distribute the plan to each county medical society.

**EMERGENCY MEDICAL SERVICES . . .** An Iowa emergency medical services plan is proceeding in its development. W. R. Bliss, M.D., Ames, is chairman of the State EMS advisory council. It is anticipated the state will be divided into 4 EMS regions.

**IMMUNIZATION . . .** October is Immunization Action Month nationwide and the IMS is cooperating in Iowa efforts to stimulate public interest in this important subject. Mrs. E. J. Drew, representing the IMS Auxiliary, is serving as chairperson of the 1975 Iowa Immunization Advisory Committee. Literature, news releases, etc., are expected to be distributed in October calling attention to the need for protection against the immunizable diseases. Society members are urged to stress the subject as much as possible.

*(Please turn to page 392)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 9
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## TABLE OF CONTENTS

Inflation and Medicine 1954-1974
Howard D. Baker . . . . . 381

Male With a Uterus and Fallopian Tubes: A Rare Disorder of Sexual Development
James M. Caterine, M.D., Robert F. Valestin, M.D., and Joseph Song, M.D. . . 385

Late Hematogenous Infection in Total Joint Replacement
Richard A. Brand, M.D. . . . . 388

A Protocol for the Safe Administration of Adult Parenteral Nutritional Solutions
Susan Bauman, R.N., and Joel B. Freeman, M.D. . . . . 391

## EDITORIALS

October Is I.A.M. . . . . 395

The Woe of Surgeon Joe . . . . . 396

## SPECIAL DEPARTMENTS

President's Page . . . . . 376

Iowa Medical Miscellany . . . . . 377

The Question Box
Medical Licensure . . . . . 379

In the Public Interest
Involvement on Behalf of the Iowa Physician . . . . . 382

Educationally Speaking . . . . . 383

State Department of Health
1975 Influenza Vaccine Season . . . . 399

Medical Assistants . . . . . 398

About Iowa Physicians . . . . . 404

Deaths . . . . . 407

## MISCELLANEOUS

Thanks to Physicians . . . . . 380

Continuing Education Courses and Conferences . . . . . 383

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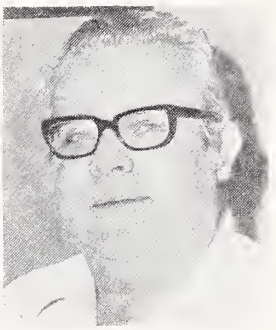
# The Question Box



by JOHN M. RHODES, SR., M.D.

*As chairman of the newly-organized State Board of Medical Examiners, Dr. Rhodes answers several questions relating to licensure. He practices general medicine in Pocahontas.*

**What is the make-up of the new Board of Medical Examiners?**

There are nine positions on the new Board with seven of these assigned to physicians and two to consumers. One consumer appointment is still to be made by the Governor. The Board now includes K. R. Carrell, D.O., Columbus Junction; H. G. Ellis, M.D., Des Moines; C. L. Beye, M.D., Sioux City; F. V. Hetzler, D.O., Davenport; H. R. Hirleman, M.D., Cedar Rapids; R. B. Neligh, M.D., Council Bluffs; and Shelia D. Sidles, Centerville, in addition to myself. Dr. Carrell is vice-chairman and Dr. Ellis is secretary.

**What is the trend in numbers of physicians seeking Iowa licenses?**

The following figures speak to this question and represent those physicians who have obtained new Iowa licensure by examination or endorsement.

| | M.D. | D.O. | Total |
|---|---|---|---|
| 1970-71 | 240 | 27 | 267 |
| 1971-72 | 267 | 36 | 303 |
| 1972-73 | 313 | 36 | 349 |
| 1973-74 | 377 | 44 | 421 |
| 1974-75 | 411 | 43 | 454 |
| | 1,608 | 186 | 1,794 |

**What is the status of the Board's consideration of continuing medical education?**

Formal CME action is in abeyance pending further legislative consideration. It should be noted the Board was impressed with the findings of the 1973 CME survey taken by R. M. Caplan, M.D., in cooperation with the IMS Committee on Medical Education and Hospitals. This survey showed Iowa physicians are devoting an extraordinary amount of time, effort and money voluntarily to their educational pursuits.

The Board's previous CME recommendations, as presented to the General Assembly, declared (1) any legislation should be permissive and give the Board authority to establish CME requirements by rule and regulation; (2) any required CME documentation should be related to licensure renewal and not to re-certification; (3) any CME program associated with licensure renewal should give the Board authority to grant exemptions under certain circumstances; (4) any required CME program should be broad-based and permit a diversity of learning experiences; (5) any physician should qualify for licensure renewal (a) through active membership in the American Academy of Family Physicians, (b) through receipt of a current AMA Physician Recognition Award or other nationally recognized CME citation, (c) through completion of 150 hours of CME over a 3-year period, or (d) through satisfactory completion of an acceptable re-certification program. Other CME alternatives have been discussed and will receive further consideration. As is apparent, the idea of flexibility has been stressed.

**Is it correct to say the job of the Board of Medical Examiners is to assure the initial qualifications of a physician and to maintain surveillance over the provision of quality care to Iowans? If so, is the mission being met?**

The short- and long-term goals of the Board are to administer and enforce the law relating to the practice of medicine and surgery, osteopathic medicine and surgery and osteopathy and administer the physician's assistants act.

*(Please turn to page 380)*

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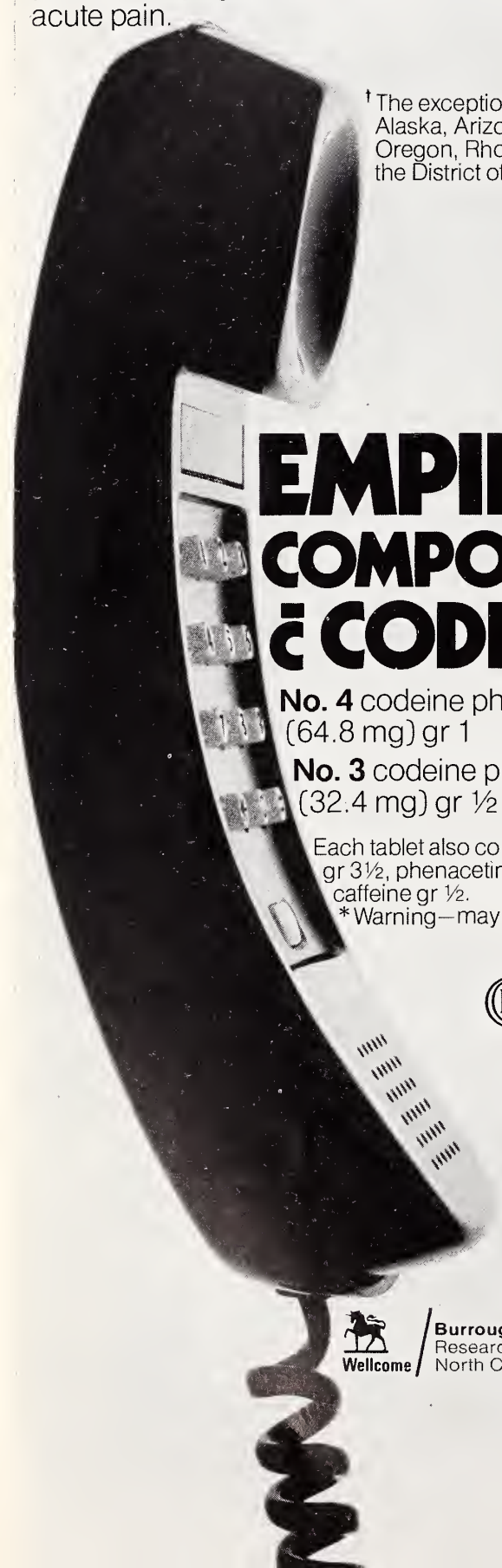

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## QUESTION BOX

*(Continued from page 379)*

The Board conducts two examinations each year in June and December, determines the eligibility of candidates for licensure by endorsement, issues resident physicians' licenses and temporary licenses and determines the eligibility of candidates to be certified as physician's assistants. The Board also investigates violations of the Medical Practice Act and conducts hearings to suspend or revoke licenses when disciplinary proceedings become necessary. The real maintenance of quality care is more in the realm of peer review as performed by the profession broadly through the Iowa Medical Society and the Iowa Foundation for Medical Care.

Within the scope of its resources and staffing, I believe the Board of Medical Examiners is performing its duties in an efficient manner.

## THANKS TO PHYSICIANS

In early June, The University of Iowa College of Medicine distributed a letter to all family physicians, general internists and pediatricians in the state. This letter requested an expression of interest in service as a physician preceptor during the coming year. Two-week preceptorships are required of junior medical students at The University of Iowa.

According to Harold Moessner, M.D., as spokesman for the Preceptorship Advisory Committee and course director, the response to the June mailing has been excellent. Over 200 replies have been received from throughout the state.

Dr. Moessner reports that because there are only 175 junior students some of the physicians expressing a willingness to have a preceptor will have to be passed over this year.

"This overwhelming response indicates and demonstrates the high level of interest in medical education which exists among Iowa physicians," said Dr. Moessner. "I want to express my sincere appreciation to all who have replied to the request."

The response from students who have completed the required preceptorship has been generally very favorable. An evaluation is made of each experience.

# Inflation and Medicine 1954-1974

HOWARD D. BAKER
Waterloo

*Productivity of physicians has increased 35% between 1954 and 1974, according to the author. Even so, the physician is not quite keeping pace with inflation in relation to spendable income.*

A GREAT DEAL of attention has been given to the increase in the cost of medical care over the past 20 years. The basic premise is true, there has been a substantial increase.

However, in evaluating this increase in the cost of medical care, several factors must be considered. First, "medical care" must be subdivided into actual physician costs and non-physician costs, such as hospital care, custodial care, drug costs, and other non-physician care costs. Second, and equally important, we must consider that the average person—with increased insurance coverage, purchasing power and welfare—requires or demands more care than 20 years ago. In other words, while the cost of the same medical care has increased, there has been an equally significant increase in the amount of medical care.

In analyzing this subject, we did some random sampling of figures on inflation, physician fees and physician income for the 20-year period 1954 to 1974. Statisticians would very probably regard these figures as superficial and perhaps inconclusive, but they do give us a "bird's-eye-view" of what has happened over this 20-year period.

Using a base of 100% for 1954, the Consumer Price Index would have been 110% for 1959, 119% for 1964, 145% for 1969 and 203% for 1974. This index has risen 103% in 20 years, with a 45% increase the first 15 years and 58% the last 5 years.

Mr. Baker is manager of the Financial Planning Department for Professional Management Midwest.

In attempting to relate this rate of inflation to physician medical care, we sampled fees in nine medical specialties and found that fees have gone up an average of 74% with the individual increases ranging from 133% for some office calls down to a low of 47% for refractions by ophthalmologists. It appears physicians' professional fees in areas we service have gone up about 29% less than the Consumer Price Index.

Inflation—As Measured by the Consumer Price Index, U. S. Department of Labor:

From 1954-1959—Average Annual Inflation—2.0%
From 1959-1964—Average Annual Inflation—1.3%
From 1964-1969—Average Annual Inflation—4.2%
From 1969-1974—Average Annual Inflation—6.7%
1973 Rate— 6.2%
1974 Rate—11.0%

Next, we sampled net professional income for physicians in these same nine specialties and found net income had risen from an average for nine specialities of $30,400 in 1954 to an average of $71,200 for 1974, an increase of 134%. This is 31% higher than the Consumer Price Index rise.

However, we immediately concluded if average fees have increased 74% and profits have increased 134%, increased productivity has to account for the remaining 60% increase in profit. Considering the 74% increase in fees on the increased productivity indicates that our average client in these nine specialities is actually achieving about 35% more physical production than in 1954.

Then comes the "great equalizer"—federal and state income taxes. On the average income of the nine specialities in 1954 of $30,400, the federal and state tax burden would have been about $7,400, leaving $23,000 spendable income. In 1974, on a $71,200 income, the tax burden would have been about $24,700, leaving $46,500 spendable income. This is an increase in spendable income of 102% or 1% less than the rise in the Consumer Price Index.

*(Please turn to page 395)*

# INVOLVEMENT OF THE IOWA MEDICAL SOCIETY

INVOLVEMENT, they say, is essential in this day and age. This admonition is probably as applicable to individuals as it is to business and industry, even to medical societies. An important determinant in deciding on the appropriate degree of involvement is capacity—a word that lumps together time, personnel, resources, etc.

Obviously, if you are a physician seeing patients 65-70 hours a week, the time for involvement in community endeavor has to be restricted. Even so, many are deeply involved. What's more, the Iowa Medical Society is a long-standing instrument through which the profession conducts a program of statewide involvement.

*How and where is the Iowa Medical Society involved?* This question is asked periodically—both by curious and unknowing observers and by actual dues-paying member physicians.

Space restricts any comprehensive accounting of Iowa Medical Society involvement. But it may be informative to note some of the current activities, programs, etc., in the sense of an over-view.

• **Medical Liability**—The Iowa Medical Society is heavily involved in seeking solutions to this country-wide dilemma. The 1975 passage of House File 803—with its several remedial provisions—by the Iowa General Assembly was strongly encouraged by the IMS. Now pursuit is being given by the IMS, the lawmakers and others to more permanent answers to the complex problem. The Society's Medico-Legal and Legislative Committees are providing principal leadership in this crucial area.

• **Health Planning**—New governmental mandates have come down requiring health services to be planned under a different organizational framework. The National Health Planning Resources Development Act of 1974 is bringing with it the need for health service areas and health service agencies. Society representatives are involved in the early implementation of this law with the Committee on Delivery of Health Services following these developments.

• **Continuing Medical Education**—Involvement in CME is increasing steadily. The Iowa Medical Society is building on a tradition of providing an annual scientific program by implementing a new mechanism for accrediting certain in-state organizations and facilities which offer periodic CME opportunities. This and the entire CME subject, as it relates to relicensure and recertification, are under the scrutiny of the IMS Committee on Medical Education and Hospitals.

• **Peer Review**—This term serves to describe the profession's efforts to assure quality, quantity and economic fairness in the delivery of medical care by Iowa physicians. Principal involvement here has been through the four-year-old Iowa Foundation for Medical Care with support and consultation from the IMS Committee on Medical Service. The federal Professional Standards Review Organization (PSRO) program is an important dimension of peer review and has received extensive attention by the IFMC and the IMS.

• **Professional Relations**—Now in the process of revision is a code of understanding which has guided the Iowa medical and pharmaceutical professions for a number of years. The code is a joint instrument of the IMS and the Iowa Pharmaceutical Association. Its updating is a project of the Committee on Interprofessional Activities.

• **Immunization**—Active encouragement of and participation in the national Immunization Action Month program is yet another Society involvement. Efforts to have each county medical society designate an immunization chairman have been in process by the Committee on Maternal and Child Health for some time.

• **Sports Medicine**—Planning is now proceeding for the third in a series of every-other-year workshops for coaches, trainers, physicians and others interested in the proper handling of young Iowa athletes. This program is a joint endeavor of the Committee on Sports Medicine and the Iowa High School Athletic Association.

What we have here is simply an array of the involvements of the Iowa Medical Society. These are important involvements. There are additional important ones not listed. All told, it's a formidable and challenging menu.

# IN THE PUBLIC INTEREST

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## ARE YOU EASILY WEANED?

In a brief piece published in the NEW ENGLAND JOURNAL OF MEDICINE (292:750, April 3, 1975), Dr. William Poe of Roanoke, Virginia discussed the "principle of weaning." His interesting insights are fun as well as important. Having defined weaning as the "detaching of the affections from something long followed or desired," he then makes the leap to the general phenomenon of change in behavior. And, since learning is sometimes defined as the production of a change in behavior, you can see why I think his views are of some interest in the field of continuing education.

Dr. Poe continues, "Weaning from one way of doing something to another way of doing something is fraught with pain, even in its contemplations. Look around. Isn't the sense of turmoil in the practice of medicine and in medical education a result of lack of weaning, the failure to allow time for detaching our 'affections from something long followed'?" Reflect on yourself. Are you easily weaned? Do you find it rather easy or rather hard to abandon whatever facts and rules (?dogma) you learned in medical school or beyond? If you're fond of making Freudian interpretations about physicians who learn (and therefore change) readily vis-a-vis their relative security as infants, then go ahead and indulge yourself—the door is wide open. But in any case we must recognize that adaptability is increasingly important to today's world, and especially tomorrow's. That, in a nutshell, is the summary message of Alvin Toffler's *Future Shock*. Envision, in allegory, a bespectacled, sage old "grandpa" among the dinosaurs who warned all his fellows and offspring that they must learn to adapt, or else perish. Or is it, instead, hot-blooded young radicals who trumpet that same message throughout the eons? Maybe the ability to perceive that particular truth isn't much related to age. To say it differently, maybe it doesn't matter whether you *are* an old dog, but rather, how you *feel* about that bromide that says you can't teach new tricks to an old dog.

Dr. Poe pursues his analysis of weaning into the care of patients. He concludes, "To be good healers, we need to be good weaners." To be effective in all human interactions means that we must be persuasive in bringing about change in others, whether we call ourselves educators, salesmen, physicians, parents, lovers or whatever. To make our personal efforts in continuing medical education really pay off, we must work to assure that we are readily weanable.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

# Continuing Education Courses & Conferences

*Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.*

| | |
|---|---|
| Sept. 12 | Postgraduate Conference in Surgery |
| Sept. 13 | Cancer Teaching Day |
| Sept. 25-26 | Pediatric Conference |
| Sept. 26-27 | Postgraduate Conference in Urology |
| Sept. 27-28 | Orthopedic Alumni Meeting |
| Oct. 1 | Diet Therapy U.S.A. |
| Oct. 3-4 | Dermatology for the Dermatologist |
| Oct. 6-9 | Surgical Technique in Cleft Lip and Palate |
| Oct. 13 | Cardiology Today |
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SCIENTIFIC ARTICLES

# Male With a Uterus and Fallopian Tubes: A Rare Disorder of Sexual Development

JAMES M. CATERINE, M.D.,
ROBERT F. VALESTIN, M.D., and
JOSEPH SONG, M.D.
Des Moines

*An unusual case of hernia uteri inguinali caused by defective müllerian regression is reported in an otherwise normal male. Brief discussion is presented of intrauterine sexual differentiation and pseudohermaphroditism.*

MALE PSEUDOHERMAPHRODITISM, in which genetic males differentiate partly or completely as phenotypic females, can result from disturbances in any of the three physiologic events necessary for virilization of the male embryo—namely, defects in androgen synthesis, defects in androgen action and defects in müllerian duct regression.[1–4]

In addition to these three forms of defective virilization, in which the pathophysiologic derangement can be classified, a variety of other forms of hereditary male pseudohermaphroditism have been described in which the failure of virilization is incomplete and in which the pathogenesis is less clear.[7]

Disorders of androgen synthesis are inherited as autosomal recessive traits and are due to defects in one of the five enzymatic reactions required for testosterone formation from cholesterol, which are sequentially the 21,22-desmolase, 3 Beta-hydroxysteroid dehydrogenase, 17-hydroxylase, 17,20-desmolase, and 17-ketosteroid reductase reactions.[8, 9]

The most clear-cut example of defects in androgen action is the testicular feminization syndrome, which is inherited as an apparent X-linked recessive trait and which represents the most complete defect of masculinization. This syndrome, including the failure of male sexual differentiation during embryogenesis and the defective virilization in the postpubertal state, is believed to be the result of a single biochemical defect in testosterone action, although the precise site is not known.[8, 10, 11]

Defective müllerian regression results in the persistent müllerian duct syndrome (hernia uteri inguinali), in which female internal genitalia are present in otherwise normal men.[10–12] This dis-

The authors are associated with the Departments of Surgery, Gynecology and Pathology at Mercy Hospital in Des Moines, Iowa.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF SEPTEMBER, 1975.

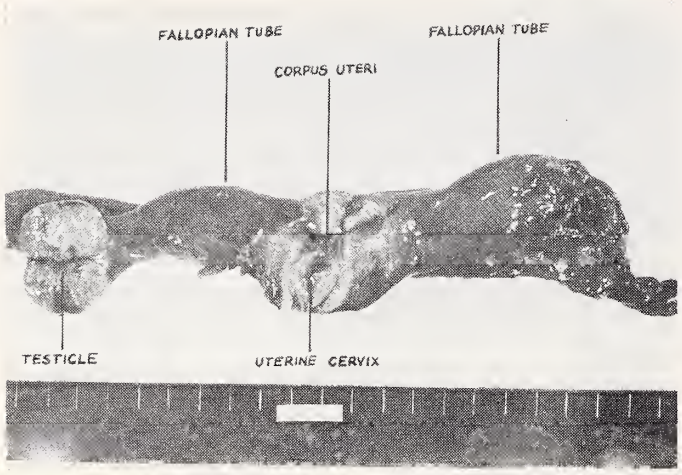


Figure 1

order appears to be inherited as a recessive trait, either autosomal or X-linked.[5–7]

The purpose of this article is to report a case of hernia uteri inguinali caused by defective müllerian regression in an otherwise normal male.

## REPORT OF A CASE

Mr. J. P., a 26-year-old male patient, was admitted to Mercy Hospital, Des Moines, Iowa, for evaluation of complaints of lower abdominal pain, radiating into the back and associated with nausea and vomiting. His past medical history was unremarkable. There was no history of previous surgery. He was the father of a male child. His wife was treated for ovarian dysfunction, which was thought to be the residual of Sheehan's syndrome, following the birth of the child.

Physical examination on admission revealed mild lower abdominal tenderness, without guarding, rebound, or rigidity. No palpable abdominal masses were noted. The rectal examination was normal. A left inguinal hernia was noted. The external genitalia were within normal limits, except for an undescended testicle on the right side. The

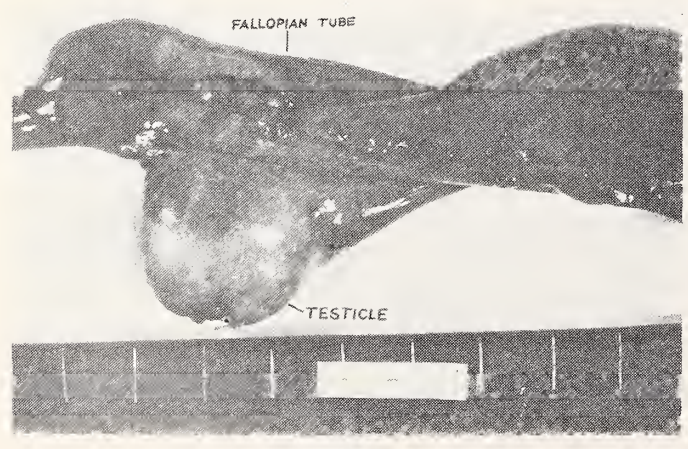


Figure 2

routine laboratory examinations on the blood and urine were normal. An intravenous pyelogram was normal. Radiological examination of the chest was also reported as normal. The clinical impression was an early acute appendicitis or an intra-abdominal torsion of the undescended right testicle.

Two days later, when the abdominal pain and tenderness subsided, the patient was taken to surgery for repair of the left inguinal hernia and either orchipexy or orchiectomy for the right undescended testicle. Upon exposing the hernia sac, on the left side, the testicle suddenly retracted into the abdominal cavity via the internal ring. The sac was opened, and when the testicle was retrieved, a fallopian tube with a fimbrinated end appeared with the testicle attached to it. With gentle traction, there was visualized a most unusual structure resembling the uterus and cervix with right fallopian tube, with a round structure which had the appearance of an ovary (Figure 1). The frozen section examination of the left testicle, which had retracted into the abdominal cavity, proved to be a testicle with normal spermatogenesis. The right adnexal mass, resembling an ovary, was an atrophic testicle (Figure 2).

The uterus and cervix were well formed, measuring 7 x 5 x 3 cm, maintaining the normal figure of adult female uterus with cervix attached. Both fallopian tubes were also well developed, having normal anatomical distribution of the normal female fallopian tubes. No ovaries were, however, found in either adnexa, which had the usual amount of broad ligament. The left testicle and its vas and vascular structures were then dissected from the broad ligament and were replaced and fixed in the scrotum. A hernia repair followed. The uterus, both fallopian tubes, and the right atrophic testicle were removed,

The endometrial glands and the stroma were well formed, although they were rather inactive, simulating a proliferative endometrium. The endometrial glands showed mild pseudostratification with no mitotic figures. The endocervix showed considerable fibrosis of the stroma and foci of lymphocytic infiltrates. No chronic cystic endocervicitis was found. Both tubes maintained normal histologic structures of the mucosa and the submucosa. A portion of the left testicle, which was placed back in the scrotum, showed normal spermatogenesis and well-preserved tubular structures. The interstitial cells were occasionally seen. The right testicle, however, was

markedly atrophic and fibrosed, having no spermatogenesis.

## CHROMOSOME STUDIES

The buccal smears were examined for Barr bodies, which were not found in any of the squamous epithelial cells. A karyotype was performed, which showed a model chromosome number of 46, with XY sex chromosomes.

The urinary 17-ketosteroids excretion was within normal limits (14.3 mg/day).

The patient's postoperative course was uneventful, and he was discharged on the 12th postoperative day.

## DISCUSSION

Until about the sixth embryonic week, gonadal differentiation proceeds in the same fashion for both chromosomal males and females. At that time, in the embryo destined to be a male, sex-determining genes from the Y chromosome are thought to evoke inductor substances from the primitive medulla of the urogenital ridge, which causes involution of the cortex and continued differentiation of the medulla into testes. The opposite occurs under the influence of sex-determining genes from the X chromosome in the female. It appears that both sex chromosomes must be present in order for ovarian differentiation to occur, since it has been noted that ovarian differentiation does not occur in the XO individual. The Y chromosome contains powerful male-determining genes, which is supported by the fact that testicular differentiation occurs even when there is more than one X chromosome, as in a type of Klinefelter's syndrome with an XXY pattern, and also in individuals with an XXXXY karyotype, whereas no testicular differentiation is seen in the XO individual (Turner's syndrome).

At the seventh week of intrauterine life, the embryo has the primordia of both the male and female internal genitalia. The müllerian duct system is the precursor of the uterus and fallopian tubes, and the wolffian duct system gives rise to the vas, epididymis, seminal vesicles, and ejaculatory duct in the male. Normally by the third fetal month one of these systems completes its development, and the other undergoes involution. The testes play a rather decisive role in the differentiation of the internal genitalia. Full development of the müllerian duct system with involution of the wolffian system occurs when the testicular influence is not present. Ovarian differentiation of the primordial gonad is not necessarily a prerequisite for this to happen, since this set of events occurs even when the gonads have been removed in the early embryo. External genital differentiation is directly related to androgenic stimulation by the fetal testes. If no such stimulation occurs, feminization of the external genitalia results. Differentiation along the male line requires androgenic hormone activity.

Retention of müllerin duct structures in the presence of normal male internal and external genitalia in this patient with a normal XY karyotype represents either a failure of the fetal testes to elaborate the duct-organizing substance, or failure of the müllerian duct system to involute in response to it. This form of male pseudohermaphroditism is known as hernia uteri inguinali because it is often unsuspected until the uterus prolapses through an inguinal hernia.

While fertility is not commonly found in a male with a uterus and fallopian tubes, it has been described in cases of hernia uteri inguinali. Two male siblings with a uterus and fallopian tubes were described by Armendares and colleagues,[6] who postulated that this rare sexual development was probably an inherited disorder. The family history of this patient, however, disclosed no such possibility.

## SUMMARY

A case of a rare disorder of sexual development, manifested by a uterus and both fallopian tubes in a 26-year-old normal young man, is described. The chromosome study, along with determination of the urinary 17-ketosteroids, substantiated the male karyotype and normal range of the hormone. The intrauterine sexual differentiation and the mechanism of pseudohermaphroditism are briefly discussed.

## REFERENCES

The references noted in this article may be obtained from either the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

# Late Hematogenous Infection in Total Joint Replacement

RICHARD A. BRAND, M.D.
Iowa City

*The potential for infection in patients with total joint replacements is illustrated by two cases. Suggestion is made that subsequent active infections be treated aggressively.*

TOTAL JOINT REPLACEMENT, particularly of the hip and knee, has become more commonplace in the past few years. At the same time, greater numbers of patients with early and late complications are being recognized. One of the potentially disastrous complications is infection, which was earlier recognized by Charnley.[1] Fortunately, with appropriate techniques, the infection rate has been reduced from 4 to 12 percent in early series[1, 2, 3, 7, 9, 10, 11] to less than 2 percent in Coventry's large series.[5]

Most authors contend late infection is due to seeding at the time of surgery, if they mention etiology at all.[3] More recently, there has been evidence that late infections may be a result of seeding from other sites of infections.[6, 8] The purpose of this paper is to report 2 cases of probable hematogenous spread of infection to total joint prostheses and to recommend early and aggressive treatment of infections in patients with total joint replacements.

*Case One:* P. P. is a 76-year-old white female who in February 1970 had a right Charnley total hip replacement (Figure 1). Her postoperative course was unremarkable and 2 years after surgery she was doing well. In August 1972 she developed an abscessed tooth. After several days of pain she saw a dentist who placed her on oral Penicillin G and extracted the tooth. Five days after dental extraction she developed right hip pain and fever.

On August 10, 1972, the patient was admitted to the University of Iowa Hospitals with a temperature of 38.8 Centigrade and right hip pain. Initial x-rays were unremarkable. Aspiration of the hip revealed turbid fluid. Cultures of the fluid produced B-Hemolytic Streptococci. The pa-

Figure 1. Case #1, Post-op right total hip replacement in August 1970.

Dr. Brand is an assistant professor in the Department of Orthopaedic Surgery at the University of Iowa College of Medicine.

Figure 2. Case #1, August 1972. Note bone resorption about methyl methacrylate.

Figure 3. Case #2, Post-op left Waldius total knee replacement.

tient underwent incision and drainage without removal of the prosthesis. Postoperatively the patient has had mild intermittent pain and drainage. She has been maintained on antibiotics. X-rays in December 1974 revealed evidence of osteomyelitis (Figure 2). The patient's symptoms do not warrant further surgical intervention at the present time.

*Case Two:* K. S., a 64-year-old white male with a 35-year history of rheumatoid arthritis, underwent a right total hip replacement in December 1972, and a left Waldius total knee replacement in September 1973 (Figure 3). Following each operation the patient had an uneventful recovery, and prior to onset of his present illness he was ambulating well with crutches, the two replaced joints being essentially painless.

Two weeks prior to admission in February 1975, the patient developed an abscess over his buttock which was incised by his private physician. No antibiotics were given. The abscess cleared, but four days prior to admission, owing to pain and swelling, his physician aspirated the knee of 45 cc of purulent material which subsequently demonstrated *Staph. aureus* on culture. After aspiration the patient was placed on Cephalothin intramuscularly. The patient was then transferred to the University of Iowa Hospitals.

On admission, the patient was very ill-appearing with a temperature of 38.5° Centigrade. The knee was swollen, hot and painful. X-rays showed resorption of bone around the prosthesis (Figure 4). Reaspiration was performed and Oxacillin, two gm every 4 hours intravenously, was begun. On the following day, exploratory surgery produced approximately 100 cc of purulent material in the knee joint and about the prosthesis, which was loose. The prosthesis was removed and the bone curetted. The knee was fused with an external Charnley compression apparatus and the wound closed over constant suction-irrigation tubes.

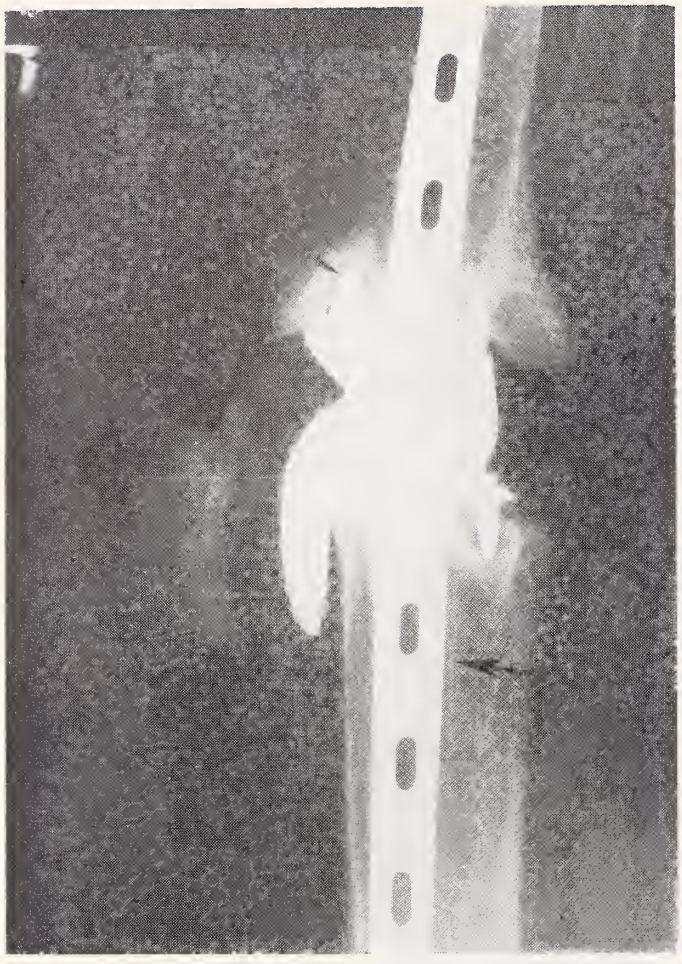

Figure 4. Case #2, February 1975. Note bone resorption.

Figure 5. Case #2, Post-op fusion left knee.

Postoperatively the patient became afebrile within 72 hours. Operative cultures of fluid and bone produced *Staph. aureus* sensitive to Penicillin G and the patient was switched to Penicillin G, 4 million units intravenously, every 4 hours for 4 weeks. Suction irrigation was maintained for 2 weeks with normal saline until cultures were negative. The pins were removed at 6 weeks, the patient was placed in a long leg walker plaster (Figure 5) and discharged. Follow-up is too short to determine whether or not the fusion will heal and whether the infection is clear.

## DISCUSSION

It is becoming increasingly apparent that total joint replacements may become infected as a result of seeding from hematogenous spread of distant infections. Although it would be impossible to prove definitely a cause-effect relationship between the antecedent infections (for which cultures were not obtained) and subsequent joint infections in the cases presented here, evidence is mounting that such infections do occur.

It has been well established that patients with prosthetic heart valves may develop infections from hematogenous seeding[4] and such patients are usually placed on prophylactic antibiotics prior to surgical procedures and dental extractions. Additionally, infections are treated aggressively to prevent the development of endocarditis.

However, the dangers of infections or potential infections have not been emphasized in patients with total joint replacements. Owing to the risks of infection at an avascular bone-implant interface and to the generally poor prognosis for infected total joints, we feel all patients with total joint replacements undergoing procedures in which there is a potential for bacteremia (i.e. dental extractions, cystoscopy) should be placed on prophylactic antibiotics. Furthermore, any active infection should be aggressively treated after appropriate cultures and sensitivities have been obtained.

Only an awareness of and vigorous attention to this problem will prevent the disasters which may occur when a total joint replacement becomes infected.

## REFERENCES

The references noted in this paper may be obtained on request either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

# A Protocol for the Safe Administration of Adult Parenteral Nutritional Solutions

SUSAN BAUMAN, R.N., and
JOEL B. FREEMAN, M.D.
Iowa City

*Basic guidelines in central venous nutrition for critically ill patient are provided. Stress is placed on need for extreme care for the debilitated patient who requires nutritional support.*

Since it was first introduced in 1968, Central Venous Nutrition (CVN) has become one of the most important recent advances for providing nutritional support to the critically ill patient who cannot or will not use his gastrointestinal tract. The basic principles of parenteral nutrition have been reviewed elsewhere.[1] The purpose of this paper is to set forth a protocol which, if followed, will provide safe and efficacious delivery of CVN and should prevent most infectious and technical problems. This protocol may be fixed to hospital bulletin boards so it is readily accessible to nurses and physicians alike. Inherent in our program is the necessity for interested personnel to oversee and supervise the care of these patients. This "nutritional team" consists of a physician, a specially trained nurse epidemiologist who provides day-to-day care and pharmacists who mix the solutions.

## RECOMMENDATIONS FOR ADMINISTRATION

*(Adult patients)*

1. The recommended starting dose for the *average* patient is 90 ml/hr (two bottles per day). Increase *gradually* to 125 ml/hr (three bottles per day) by the end of the first week. The starting rate should be 40 ml/hr and the increase much more gradual in markedly debilitated patients. On the other hand, patients who tolerate 3 liters a day may frequently be increased to 4 liters per day. The increment should not exceed 25 ml/hr over any 24 hour period.

2. The rate of administration must be constant and a 200 drip chamber must be interposed between the bottle and the IV tubing. Never increase the prescribed rate to compensate for solution not given in the previous hour.

3. The standard electrolyte additives to each bottle for an average adult patient are NaCl 20 mEq and $KHPO_4$ 30-60 mEq. Ten ml of MVI* are given daily.

4. Most protein hydrolysates contain maintenance quantities of calcium and magnesium but further additions are frequently required in the form of 10% Calcium Gluconate and 50% Magnesium Sulfate. Do not mix Calcium and Potassium Phosphate—use Potassium Chloride in the bottle to which the extra calcium is added.

5. Important points in routine orders:

(a) Be sure the patient is on fractional urines with regular insulin coverage for 3+ and 4+ spillage.

(b) Many fungal infections are preceded by the appearance of Candida in the urine. Therefore, culture the urine once weekly.

(c) If a patient develops fever: culture urine, blood from the subclavian catheter *and* a peripheral vein, and at least 50 ml of the hyperalimentation fluid. Before drawing these cultures, prep each area with iodine so as not to contaminate the cultures with skin organisms. The nutritional team should be called for all septic episodes. The catheter should not be removed until it is clearly documented that the patient has septicemia or until fever has gone undiagnosed for more than 24 hours. Unexplained glucose intolerance may be the first clue to an underlying septicemia.

Ms. Bauman is a specially trained nurse epidemiologist at University Hospitals and Dr. Freeman is an assistant professor in Department of Surgery at U. of I. College of Medicine.

* Multiple Vitamin Infusion. U. S. Vitamin Pharmaceutical Corporation, Tuckahoe. New York 10707.

*(Please turn to page 393)*

## IOWA MEDICAL MISCELLANY

*(Continued from page 377)*

**ON CME . . .** August 13 meeting of the Society's Committee on Medical Education and Hospitals was held to firm plans for IMS House-approved program which accredits hospitals and other facilities that sponsor CME projects.

**PHYSICAL THERAPY . . .** Basic approval has been given by the IMS Executive Council to an agreement on the essential elements of physical therapy devised by the IMS, the Iowa Physical Therapy Association and the Iowa Hospital Association. Adoption of this statement depends in part on resolution of the recent opinion of an assistant attorney general.

**PHYSICIAN/PHARMACY CODE . . .** A revised IMS/IPhA Code of Understanding has been approved at the committee level and will now be submitted to the IMS Executive Council in October and to the IPhA House of Delegates in September.

**AUXILIARY SUPPORT . . .** An $8,000 loan has been made to the Scanlon Medical Foundation/Iowa Medical Society by the IMS Auxiliary. These funds to support the Foundation's medical student loan program are from the Auxiliary's health education loan fund. Acknowledgment of this significant action has been made to Auxiliary President Mrs. J. F. Veverka by Foundation President A. J. Havlik, M.D.

**VIETNAMESE PHYSICIANS . . .** Six Vietnamese physicians recently located in Iowa began a 4-month study program at The University of Iowa College of Medicine in August to prepare for the ECFM examination. The enrollees have the following sponsoring communities: Monona, Nashua, Sumner and Mason City (3). Norman Hoover, M.D., Mason City, is serving as an informal advisor to the U. of I. program. Dr. Hoover served as associate dean of the University of Saigon medical school for several years.

**TEACHER EXAMS . . .** Local school boards now must require employees (teachers, food service personnel, drivers, etc.) to provide at 3-year intervals a written report of a medical examination by a physician which shall include a TB check and certifying each examinee is fit to perform the assigned tasks.

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*Warnings:* Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

*Precautions:* Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

*Adverse Reactions:* Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

*Dosage and Administration:* The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

*How Supplied:* Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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*(Continued from page 391)*

(d) When a patient is started on CVN, the CVN nurse changes the dressing and IV tubing every Monday, Wednesday and Friday. In her absence or in the event that the dressings should become contaminated or soaked, nursing staff who have been properly trained may do the dressing. However, technical problems related to poor flow MUST BE TREATED BY A DOCTOR. This includes irrigation of the catheter.

6. The incidence of skin irritation and phlebitis is reduced if the catheter is sutured in place at the time of insertion. This is greatly facilitated by cutting away the hub of the catheter, removing the needle and fitting a #18 gauge *blunt* needle into the catheter. A nylon suture is tied around the catheter using the needle as a stent, and a second suture is placed around the catheter at skin level.

7. A subclavian or internal jugular line is the safest. Long lines inserted via the brachial vein or from the external jugular are dangerous and associated with an inordinately high infection rate.

8. It is best to regard the CVN system as completely closed from the bottle to the subclavian catheter.[2] UNDER NO CIRCUMSTANCES SHOULD DRUGS OR PLASMA BE ADDED TO THE CVN BOTTLE OR PIGGYBACKED INTO THE TUBING. STOPCOCKS MUST NEVER BE USED FOR DRAWING BLOOD, ADMINISTERING FLUIDS OR CVP DETERMINATIONS. PATIENTS WHO REQUIRE SOLUTIONS OR DRUGS IN ADDITION TO CVN MUST HAVE A SECOND IV STARTED. If no other veins are available, remove the rubber at the Y-connector of the IV line and place the second tubing directly into this orifice.[3]

9. Leakage (identifiable by a sticky feeling on the bottle or tubing) must be immediately corrected by detecting the source and changing all tubing. Since this procedure involves breaking the line, it must be done by a trained nurse or a physician.[4]

10. When CVN therapy is discontinued or the patient is scheduled for surgery, run D10/W for a minimum of five hours.

11. If therapy continues for more than two weeks, serious consideration must be given to the addition of plasma (2 units weekly) to prevent zinc and essential fatty acid deficiencies. Also note the rules for administration of vitamin K, folic acid and B-12 under the section entitled "Additives." Iron is administered intramuscularly when indicated by low serum iron levels.

12. There is no evidence that millipore filters prevent septicemia. In fact, many of the lowest CVN-related infection rates have been attained without the use of these filters.[2,3] At the University of Iowa, *the infection rate is 32% in patients with filters vs. only 8% in patients without filters.*

13. The presence of multiple catheters, prolonged administration of antibiotics, immunosuppression combined with malnutrition all place the patient at high risk for bacterial or fungal septicemia. Hence one should never consider the presence of Candida in the blood as a contaminant. These high-risk patients require special care and assiduous attention to detail. It must be appreciated that the administration of CVN is very dangerous in such patients although, on the other hand, the outcome will surely be unfavorable unless nutritional support is provided. The two most important considerations in this group of patients are whether or not another form of nutrition can be used; and, would it be more advisable to temporarily withhold CVN until the patient's clinical condition is stable. If the gastrointestinal tract is functioning, it is occasionally safer (and more economical) to perform a feeding jejunostomy. However, if CVN must be administered, attempt to discontinue antibiotics and remove as many catheters as possible.[2] We routinely use the "amphotericin flush" in such patients[5] and perform weekly cultures of both blood and urine.

## COMPOSITION OF THE CVN ADULT SOLUTION

Each 1,000 ml provides: Nitrogen—6.5 gm, Dextrose—250 gm, Sodium—30 mEq, Potassium—15.5 mEq, Calcium—5 mEq, Magnesium —2 mEq, Chloride—22 mEq and Phosphate—30 mEq. The solution supplies approximately 1 Kcal/ml.

If *additional additives* are required, they are to be ordered individually as follows. These will be in addition to the basic solution composition. The table lists the daily requirements for an average adult. (Note those additives given weekly.)

| *Additives:* | *Bottle #1* | *Bottle #2* | *Bottle #3* |
|---|---|---|---|
| Sodium (as Sodium Chloride—NaCl) | 20 mEq | 20 mEq | mEq |
| Potassium (as Potassium Chloride—KCl) | mEq | 40 mEq | mEq |
| Potassium (as Potassium Phosphate) | 30 mEq | mEq | 30 mEq |

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|---|---|---|---|
| Calcium Gluconate 10% (5 mEq Ca++/10 ml) | ___ mEq | 10 mEq | ___ mEq |
| Magnesium Sulfate 50% (4 mEq Mg++/1 ml) | ___ mEq | ___ mEq | 8 mEq |
| MVI (10 ml/day) | 10 ml | ___ ml | ___ ml |
| Vitamin K-1 (10 mg every Friday) | 10 mg | ___ mg | ___ mg |
| Folic Acid (6 mg every Friday) | 6 mg | ___ mg | ___ mg |
| Vitamin B-12 (30 mcg every Friday) | 30 mcg | ___ mcg | ___ mcg |

(Bottles should be numbered consecutively from the initiation of CVN therapy)

In order to facilitate placement of the catheter and its day-to-day care, detailed protocols of the equipment required and the technique for dressing changes are also placed on each ward. The importance of meticulous attention to detail during each dressing change cannot be overemphasized.[4] The equipment required for dressing changes includes: intravenous tubing with a soluset, extension tubing, suture removal set, three sterile medicine cups, gloves, 4 x 4 gauze, acetone, betadine solution and ointment, and tincture of benzoine. The patient is placed prone with the head of the bed flat. Using strict aseptic technique, the skin around the catheter is scrubbed with acetone followed by betadine. Next, betadine ointment is placed around the puncture site and the catheter is gently moved in and out so that some betadine is inside the catheter tract. Old blood, which tends to accumulate inside the catheter hub, is removed with a sterile Q-tip. The new tubing is flushed and then quickly inserted into the catheter with the patient holding his breath. This prevents air embolism. All connections are then secured with adhesive and a sterile dressing on which the date is written to serve as a reminder for the time of the next change.

The purpose of this article is to stress the importance of assiduous care for the debilitated patient who requires nutritional support. We have been impressed with the success of the team approach to parenteral nutrition and feel that it is important to establish basic guidelines in the form of a CVN protocol.

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# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## OCTOBER IS I. A. M.

A continuing effort is necessary to reduce the incidence of childhood disease and eliminate the threat of widespread epidemics. October has been designated IMMUNIZATION ACTION MONTH by the U. S. Center for Disease Control. The American Academy of Pediatrics, American Medical Association, American Academy of Family Physicians, National Medical Association, and American Nurses Association, among others, are included in the medical organizations joining the C. D. C. in this program. The goal is to increase the immunity levels among inadequately or unimmunized preschool children. The Iowa Medical Society is pleased to be a part of this task.

The 1973 and 1974 immunization action efforts reversed the 10-year downward trend in immunization levels in children age 1-4. Unfortunately, it is estimated that over 5 million preschoolers are still unprotected. Only 63.1% of children between 1 and 4 have been vaccinated against poliomyelitis. That is not enough to prevent epidemics. Certainly, we do not want to relive the horrors of the polio epidemics of the 1950's.

Polio is not the only problem. Statistics from C.D.C. show that in 1974 only 64.5% of children in the 1-4 age group have been immunized against measles. Measles is not a harmless disease. The devastation of measles encephalitis should remind us that this is a dread disease. We are seeing outbreaks again that should not happen.

Statistics for rubella are even worse, according to Dr. John J. Witte, Director of Immunization Division of C.D.C. In 1974, only 55.6% of the 1-4 year old children were immunized against the disease. Ten years ago an epidemic of rubella in the U. S. resulted in 30,000 miscarriages and caused serious disability in 20,000 babies.

Join in the efforts of IMMUNIZATION ACTION MONTH. Immunize the children before they reach the age for entrance into school. Share in the responsibility of assuring the high incidence of measles, poliomyelitis, rubella, pertussis, diphtheria, and tetanus is a matter of past history. Develop a philosophy of routine immunizations rather than crisis programs or sporadic drives. —M.E.A.

## INFLATION AND MEDICINE 1954-1974

*(Continued from page 381)*

Our conclusion from this brief study is that physician fees for these nine specialities rose 29% less than the price index, these doctors produced 35% more work, realized net income 31% higher than the price index—all this for the final result of having 1% less spendable income than in 1954.

Obviously, there are variations from one of the nine specialities to another, resulting in some practices benefiting and some being penalized by inflation, but generally speaking, there is no indication that physicians have contributed more than their share to inflation. On the contrary, we must conclude that our average physician client is producing about 35% more work to not-quite keep pace with inflation as it affects his own spendable income.

# THE WOE OF SURGEON JOE
## (Apology to Edgar Poe)

Once upon a midnight dreary, while I pondered, weak and weary,
O'er the trials and tribulations of the hours that went before—
While I nodded, meditating, suddenly there came a grating,
As if someone softly treading on the roof or on the floor.
"Who or what is this?" I shouted, "Speak to me I do implore."
Silence then, and nothing more.

---

Startled by the deadly quiet, coupled with incipient fright,
Added to a mental low, caused by problems of the day,
Prompted me to cast aside caution, reason, and my pride,
As I thrust the window wide, hardly daring to inveigh
'Gainst the wraith that drifted in, speaking thus to my dismay:
"Here I am and here I stay."

---

"Speak up phantom, what's your name? Who are you and what's your game?
Why this night-time visit here, to upset poor surgeon Joe?"
Answered me the specter then; came the hollow voice again:
"I have come into your den, from the years of long ago—
You have often heard of me. I'm Hippocrates, you know.
Mark my words, for this is so."

---

"Welcome to my house," I said, "but remains a certain dread—
That you care not to explore that which us will suffocate.
We are hemmed in front and back, cornered in a cul-de-sac—
Subject to renewed attack, threatened with a doleful fate—
Blamed for every god-dam thing. Listen, for I tell it straight.
Hark thee now, while I relate."

---

"Tell me spook, if that you can, where potassium all began.
Who found out the three point eight, without which we can not start?
By what logic is it so, that we cannot cut or sew
'Till the magic number show, that it's normal on the chart—
Tell me this and tell it true, else I ask that you depart.
Only this, please do impart."

---

*In verse form, D. F. Crowley, M.D., presents here a poetical editorial in which he offers his personal views on what Hippocrates might be thinking were he alive today.*

---

Then the spook most hostile got, spewing forth an awful lot—
Chiding me for this and that, calling me a stupid fool.
"What," he said, "is this I hear? Can it be that it's not clear?
Surgeons no more domineer; anaesthesia boys are cool—
They decide the proper time, their's the right to over-rule.
You are wrong, to ridicule."

---

"Calm yourself Hippocrates; steady does it if you please.
Here's another windmill which, tilting with we blunt our lance:
For insurance now we pay sums that climb up and away
To a level where I pray that we don't lose all finance.
Let me hear your candid view of this frightful circumstance.
What say you to this mischance?"

---

"Well you naive foolish dolt; none lament your dollar jolt—
Seems to me that I have heard critics who have often said

Doctors are a greedy crew, always looking to pursue
Money that they say is due, but is overcharge instead.
People say this and they quote words by Massachusetts Ted.
Surely they were not misled."

---

"Oh," I cried, "the terrible curse of that politician's purse.
How can he, a wealthy man, criticize less opulence?
He is rich; why can't he see, making money honestly
Is no sin nor infamy, but the normal preference
Of the democratic way. Spoke the ghost, "The difference:
His was by inheritance."

---

Calming down, his view I sought: "Hear me friend, what is your thought
Of the current audit craze for a case by case review?"
"That," he said, "I cannot see—well intentioned though it be—
None can judge by recipe, using charts and notes in lieu
Of the bedside judgment that is the heart and soul it's true
Of the art we must renew."

---

Stillness settled on the room, causing me then to assume
That our dialogue had come to a welcome final end.
But a glance upon his mien hinted of an unforeseen
Anger that could only mean something dreadful to portend—
Something that Hippocrates had no patience to defend—
Something basic did offend.

---

He spoke softly with reserve, struggling vainly to preserve
Self control and dignity, due to what was on his mind—
"I have heard of the report of the ruling of your Court
Granting license to abort just whenever so inclined—
Heedless of an ageless code and an ethic much maligned,
Leaving common sense behind."

---

Then his voice began to rise as he sought to emphasize
How a subtle rationale can permit a life begun
To be taken if a word is in meaning gently blurred
So the killing is obscured when the fateful deed is done.
'Terminate a pregnancy' sounds harmless to everyone
And perhaps will repel none.

---

Now contempt was in his voice: "Who will ever have a choice,
Or be safe at any time, if a standard now is set
That a life must qualify to be wanted, else it die?
And someone must certify that conditions have been met
That a life is well defined as a 'person,' or the threat
Of extinction lingers yet."

---

"Where," he thundered, "where were you when occurred this shameful coup
To put out the spark of life by abortion on demand?
Bear you then enduring shame—you the doctors who became
First in history to defame and renounce your oath to stand
Strong against the deadly scheme whence a fetal death is planned
By a former healing hand."

---

Little more did he then say, though he didn't go away.
Quiet now he seemed aloof, saddened and with spirits low—
But his wrath was clear to see, as he brushed aside my plea
That with him I did agree that a truly mortal blow
Had been struck 'gainst life itself with the doctors' help—and so—
Thus the woe of surgeon Joe.

DANIEL F. CROWLEY, M.D.

# Medical Assistants

by TENORA MEYER, CMA

## MEDICAL ASSISTANT COURSES ACCREDITED

Southeastern Community College, West Burlington, Iowa, and Iowa Central Community College, Fort Dodge, Iowa, have had their medical assisting programs accredited by the Council of Medical Education of the American Medical Association, in collaboration with the American Association of Medical Assistants.

Graduates of the programs will receive a one-year certificate. Marylee Dickson, R.N., CMA-C, is Coordinator of Medical Assistant Education at Burlington, and Joan A. Natte has a similar position at Fort Dodge.

The medical assistant program provides a basic knowledge of anatomy, physiology, medical terminology, medical law and ethics, human relations, bookkeeping, insurance, administrative, laboratory and clinical procedures.

Medical assistants aid physicians in private practice or hospital settings. The assistants are the direct link between physicians and their patients and provide a variety of services ranging from clinical and laboratory work to office management and bookkeeping.

## NATIONAL CONVENTION AGENDA

A Bluegrass Tour—"Day at the Races": (Keeneland) is scheduled October 4 from 8 a.m. to 6:30 p.m. as the opening day event for the October 4-10 National Convention in Louisville, Ky. A tour of Churchill Downs, Farmington and City Tour is scheduled from 1:30 to 5 p.m. on October 4. The AAMA Board of Trustees will meet from 9 a.m. to 5 p.m. October 4. The welcome party will occur in the evening.

Sunday (October 5) there is a tour of Shakertown and "My Old Kentucky Home" from 8:15 a.m. to 5:15 p.m. A seminar for CMA's and a Board of Trustees meeting will be held, with the convention officially opening at 7:30 p.m.

A surveyors' workshop and reference committee meetings will open the Monday session with exhibits on display. During the afternoon, there will be a local industries tour, a seminar for educators and conference of state presidents and presidents-elect. The "Belle of Louisville" party will be Monday evening.

The House of Delegates will convene Tuesday. The program also includes "Reel Review" and "Open Door Consultation for Educators." The CMA dinner is scheduled Tuesday at 8 p.m., with awards given to CMA's passing the examination this year.

Wednesday's program includes the mini-test, educational sessions, awards luncheon, workshop for educators and seminar for future CMA's. The President's Dinner will follow these events.

Educational sessions and specialty workshops will be held on Thursday with the orientation of national committees and the inaugural banquet at 7:30 p.m.

A prominent physician on the educational program at AAMA's 19th annual meeting in Louisville, is Stanley Garbus, M.D. Dr. Garbus is extensively involved in and deeply concerned with the control and prevention of hypertension.

Hypertension will be discussed during two convention sessions: first on the general program Thursday morning and later in one of the workshops stressing patient education.

Friday, October 10, the farewell breakfast will be held with the 1975-76 Board of Trustees meeting at 11 a.m. At 2:30 p.m., the post-convention tours depart for Disneyworld/Nassau Cruise (October 10-17); Disneyworld (October 10-12) and Opryland and Smoky Mountain, Fall Foliage Motorcoach Tour (October 10-17).

# 1975 INFLUENZA VACCINE SEASON

September and October should be considered "Influenza Vaccine Season" with priority given the annual immunization of high risk persons against influenza. Immunization is strongly recommended for all persons aged 65 and over, as well as younger persons who have chronic cardiac, bronchopulmonary, renal and metabolic disorders, since these groups account for virtually all the fatalities associated with influenza A outbreaks. These high risk groups should be the primary target for influenza immunization activities, with lower priority being given to other persons.

The 1975 advisory statement of the U. S. Public Health Service relative to influenza vaccine is reprinted below, presenting very concisely the epidemiologic background and specific usage recommendations for influenza vaccine, as well as describing the nature of the 1975-76 vaccine. In addition to last year's Port Chalmers A antigen, the new vaccine will contain a new type A antigen, A/Scotland, and the 1972 Hong Kong type B antigen. All persons in the high priority immunization groups should receive a single dose of the 75-76 influenza vaccine by mid-November, 1975.

## RECOMMENDATION OF THE PUBLIC HEALTH SERVICE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

### Influenza Vaccine

*Introduction*

Cases of influenza occur in the United States every year, but there is great variation in incidence and geographic extent. Periodically, influenza becomes epidemic. This appears to occur when antibody levels wane or when the antigens of prevalent influenza viruses have changed enough to render the population susceptible. More epidemics are caused by type A influenza viruses than by type B, and type A epidemics are generally more severe.

Inactivated influenza vaccine, the best available means of protection against influenza, has been variably effective, and vaccine-induced antibody appears to be relatively shortlived. Consequently, public health recommendations on influenza immunization in the United States are oriented toward protecting those at greatest risk of serious disease and death by emphasizing the selective vaccination of "high-risk" groups.

Repeated observations during most influenza epidemics indicate that fatalities are almost completely restricted to the chronically ill and the elderly, especially persons over age 65. Epidemics caused by type A influenza viruses, but rarely those caused by type B, are notable for inducing mortality in excess of what is normally expected.

People in the "high-risk" group should be vaccinated annually regardless of the amount of influenza expected in any specific geographic area. In this way, those at particular risk can maintain the highest possible level of protection. Vaccination of the "high-risk" group should be emphasized by public health authorities; now only 10-15 percent of this group are vaccinated each year.

Influenza control through widespread vaccination of the general population is not currently a public health objective for several reasons: the variable effectiveness and short-lived antibody with available influenza vaccines, the relatively low attack rates of influenza in community outbreaks, and the low frequency of serious complications from the disease in healthy people in the general population.

*Bivalent Vaccine**

The Bureau of Biologics, Food and Drug Administration, reviews influenza vaccine formula-

Source: Morbidity & Mortality Weekly Report, Vol. 24, No. 23.

*Official name: Influenza Virus Vaccine, Bivalent.

tion regularly and recommends reformulation with contemporary antigens when indicated. Bivalent influenza vaccine this year will contain type A and type B influenza viruses representative of currently prevalent strains. Each adult dose of the 1975-76 vaccine will contain not less than 1200 chick cell agglutinating (CCA) units of antigen in the following proportion: 350 CCA units of a type A strain comparable to the prototype A/Port Chalmers/1/73 (H3N2),** 350 CCA units of a type A strain comparable to the prototype A/Scotland/840/74 (H3N2) and 500 CCA units of a type B strain B/Hong Kong/5/72.

*Vaccine Usage*

*General Recommendations*

Annual vaccination is strongly recommended for persons who have such chronic conditions as 1) heart disease of any etiology, particularly with mitral stenosis or cardiac insufficiency, 2) chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, bronchiectasis, tuberculosis, and emphysema, 3) chronic renal disease, and 4) diabetes mellitus and other chronic metabolic disorders.

Annual vaccination is recommended for older persons, particularly those over age 65 years, because influenza outbreaks are commonly associated with excess mortality in older age groups.

Vaccination may also be considered for persons who provide essential community services if local priorities justify. However, before undertaking such an immunization effort, those responsible should take into account a number of reasonable constraints: difficulties inherent in predicting influenza epidemics, variability in vaccine effectiveness, availability of vaccine, and cost.

Vaccination of patients not at "high risk" in an attempt to reduce their chances of acquiring influenza is a decision for practicing physicians.

Pregnancy is not an indication for or against influenza vaccination.

*Schedule*

The primary series of bivalent influenza vaccine has traditionally been 2 doses. Data indicate that with the more potent influenza vaccines available in recent years, the second dose provides little additional benefit. It is, therefore, reasonable to give a single dose of vaccine for either primary or annual booster vaccination. Dose volumes for adults and children and the recommended route of administration are specified in the manufacturers' package labeling.

Influenza vaccine should be administered by mid-November.

*Reactions*

Influenza vaccines from all manufacturers are highly purified and should produce few severe adverse effects. Local reactions such as erythema and tenderness at the injection site, however, are relatively common. Mild systemic reactions, including low-grade fever, chills, myalgias, or headache, reportedly occur in up to 20 percent of adult recipients. Fever appears to be more common in children than in adults, and febrile convulsions in children under 3 years of age have been described. This possible adverse reaction must be recognized in vaccinating infants and young children who are in the "high-risk" group

**The World Health Organization has recommended a new system of nomenclature for type A influenza viruses that includes their strain designation and a description of the 2 surface antigens, hemagglutinin (H) and neuraminidase (N).

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(see General Recommendations). As an adjunct to influenza vaccine, antipyretic therapy may be considered.

*Precautions*

Influenza vaccine is prepared from viruses grown in embryonated eggs and should not be administered to persons clearly hypersensitive to egg protein, ingested or injected.


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# IMMUNIZATION REQUIREMENTS FOR TRAVELERS

**EUROPE:** There are no vaccination requirements for travel directly between the United States and countries in Europe. If an outbreak of smallpox, cholera, or yellow fever occurs in any of these countries, and if the traveler visits an infected area, most countries remaining on his or her itinerary will require a Smallpox Certificate; a few countries will require a Cholera or Yellow Fever Certificate. The countries which are considered to comprise Europe include:

Albania
Austria
Azores
Belgium
Bulgaria
Czechoslovakia
Denmark
Faroe Islands
Finland
France
Germany (East)
Germany (West)
Gilbraltar
Greece
Guernsey,
Alderney & Sark
Hungary
Iceland
Ireland
Isle of Man
Italy
Jersey
Liechtenstein
Luxembourg
Malta
Monaco
Netherlands
Norway
Poland
Portugal
Romania
Russia (USSR)
Spain
Sweden
Switzerland
United Kingdom
(England, Scotland,
Northern Ireland &
Wales)
Yugoslavia

**CANADA AND MEXICO:** There are no vaccination requirements for travel directly between the United States and either of these countries. If an outbreak of smallpox, cholera, or yellow fever occurs in any country and the traveler visits an infected area, a Smallpox Certificate will be required by both Canada and Mexico, and a Yellow Fever Certificate by Mexico but not by Canada; neither country would require a Cholera Certificate.

**THE CARIBBEAN:** There are no vaccination requirements for travel directly between the United States and any *one* of the Caribbean countries. For travel to more than one country in the Caribbean, check the individual country requirements. If an outbreak of smallpox, cholera, or yellow fever occurs in any of these countries, and if the traveler visits an infected area, most countries remaining on his or her itinerary will require a Smallpox Certificate; a few countries will require a Yellow Fever Certificate. No Caribbean country has a cholera vaccination requirement. The countries which are considered to comprise the Caribbean are listed below:

The Bahama Islands
Cayman Islands
Greater Antilles:
Dominican Republic,
Haiti, Jamaica
Lesser Antilles:
Aruba, Bonaire, Curacao,
Trinidad, and Tobago
All Leeward Islands:
Anguilla, Antigua,
Barbuda, the British
Virgin Islands,
Guadeloupe, Montserrat,
Nevis, Redonda, St. Kitts,
and St. Martin
All Windward Islands:
Barbados, Dominica,
Grenada, The Grenadines,
Martinique,
St. Lucia, and
St. Vincent

**RETURN TO THE UNITED STATES:** To return to the United States, smallpox vaccination is the only requirement and that is necessary only if, within the 14 days before arrival in the United States, the traveler has been in a country reporting smallpox.

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Source: U. S. Department of Health, Education, & Welfare, Public Health Service, Atlanta, Georgia, *Health Information for International Travel*, Supplement to Morbidity & Mortality, Vol. 23, Weekly Report, September, 1974.

For information concerning vaccinations, contact your local health department or the Division of Disease Prevention, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319. Telephone 515/281-5424.

# Morbidity Report for July, 1975

| Disease | July 1975 | 1975 to Date | 1974 to Date | Most July Cases Reported From These Counties |
|---|---|---|---|---|
| Amebiasis | 1 | 12 | 20 | Boone |
| Chickenpox | 19 | 6615 | 6174 | Des Moines, Dubuque, Monroe, Palo Alto |
| Conjunctivitis | 14 | 856 | 521 | Clinton, Dubuque, Johnson |
| Gastrointestinal viral inf. | 38 | 14690 | 5551 | Clinton, Des Moines, Johnson, Washington, |
| Hand, Foot & Mouth Disease | 5 | 10 | | Union |
| Hepatitis, A (Infectious) | 6 | 98 | 186 | Johnson, Linn, Muscatine, Woodbury |
| Hepatitis, B (Serum) | 8 | 58 | 57 | Dubuque, Johnson, Linn, Page, Polk |
| Hepatitis, type unspecified | 2 | 23 | 23 | Linn, Scott |
| Histoplasmosis | 6 | 18 | 11 | Jasper, Johnson, Linn, Mahaska, Page |
| Impetigo | 1 | 326 | 195 | Des Moines |
| Infectious Mononucleosis | 13 | 798 | 610 | Henry, Johnson, Scott, Woodbury |
| Influenza-like illness | 7 | 36126 | 89371 | Buena Vista, Des Moines, Johnson, Polk |
| Meningitis | | | | |
| Aseptic | 2 | 5 | 25 | Clinton, Polk |
| Bacterial | 1 | 8 | | Linn |
| ECHO 4 | 1 | 1 | | Harrison |
| *S. Pneumoniae* | 1 | 2 | | O'Brien |
| Type unspecified | 1 | 24 | 21 | Scott |
| Mumps | 12 | 994 | 1611 | Dubuque, Lee, Monroe, Palo Alto, Polk |
| Pasteurellosis | 1 | 1 | | Wapello |
| Pediculosis | 5 | 205 | 250 | Delaware, Jefferson, Johnson, Keokuk |
| Pneumonia | 38 | 725 | 590 | Cedar, Hamilton, Johnson, Mahaska, Scott |
| Rabies in Animals | 10 | 70 | 83 | Scattered |
| Rocky Mountain Spotted Fever | 1 | 4 | 3 | Polk |
| Roseola | 2 | 9 | | Dubuque, Jefferson |
| Rubella | 10 | 29 | 15 | Johnson, Polk |
| Rubeola | 116 | 575 | 134 | Clinton, Dubuque, Muscatine, Polk |
| Salmonellosis | 13 | 99 | 107 | Scattered |
| Scabies | 11 | 258 | 56 | Black Hawk, Polk, Woodbury |
| Shigellosis | 7 | 43 | 112 | Dubuque, Polk, Pottawattamie, Tama |
| Streptococcal infections | 202 | 6690 | 7010 | Henry, Jackson, Johnson, Marshall, Polk |
| Toxoplasmosis | 7 | 11 | | Scattered |
| Tuberculosis, total ill | 13 | 78 | | Scattered |
| Tuberculosis, bact. positive | 4 | 32 | | Cerro Gordo, Jasper, Muscatine, Scott |
| Venereal Diseases | | | | |
| Gonorrhea | 570 | 3768 | 3492 | Black Hawk, Linn, Polk, Scott, Woodbury |
| Syphilis | 18 | 175 | 241 | Black Hawk, Polk, Scott, Story |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | | | | |
|---|---|---|---|---|---|---|
| Cytomegalovirus | 2 | Herpes simplex | 9 | Herpes zoster | 4 | |

## INDEX TO ADVERTISERS


Burroughs Wellcome Co. ..... 380

Geigy Pharmaceuticals ..... 398A, B
Georgia Academy of Family Physicians ..... 407

Lilly, Eli, & Co. ..... 373
Loma Linda Foods ..... 384

Medical Protective Company ..... 406
Milwaukee Sanitarium Foundation, Inc. ..... 400

Navy Medicine ..... 405

Pharmaceutical Manufacturers Association .... 402D, 403
Prouty Company ..... 394

Robins, A. H., & Co. ..... 378A, B
Roche Laboratories .... 374-375, 392B, C, 402B, C, 411-412
Roerig, J. B., & Co. ..... 402A

Searle, G. D., & Co. ..... 392, 392A
Smith, Kline and French Laboratories ..... 392D

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

**Preparation and distribution of patient drug information**

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

**Realistic problems must be considered**

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

**What information is appropriate?**

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

**Positive aspects of patient drug information**

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

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Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

**Emotionally unstable patients pose a special problem**

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

**Legal implications of the patient package insert**

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

**How do we handle an insert for medication used for a placebo effect?**

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

**Preparation of the package insert**

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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# About IOWA Physicians

**Dr. L. A. Miller,** North English physician for 51 years, was honored by the North English High School class of 1915 at its alumni banquet. Dr. Miller was presented a plaque, a mantel clock and a gift for English Valley Nursing Care Center. Dr. Miller received the M.D. degree at U. of I. College of Medicine in 1923, interned at University Hospitals in Iowa City and returned to his hometown in 1924 to begin medical practice. . . . **Dr. Paul Jacobson** began the family practice of medicine in Monticello in July. A 1972 graduate of U. of I. College of Medicine, Dr. Jacobson interned at St. Joseph's Hospital and the Marshfield Clinic in Marshfield, Wisconsin. . . . **Dr. Jon Yankey** joined **Dr. James W. Lannon** in family practice in Mason City in June. A native of Mason City, Dr. Yankey received the M.D. degree at U. of I. College of Medicine and interned at Miller Hospital in St. Paul, Minnesota. He recently completed two years of residency training in family practice at St. Joseph Mercy Hospital in Mason City. . . . **Dr. Robert Mailliard,** Storm Lake, has been elected to a three-year term on St. Mary's school board. . . . **Dr. Richard J. Bealka,** Independence, was installed as president of Iowa Psychiatric Society at annual meeting of American Psychiatric Association in Anaheim, California. . . . **Dr. Nelson Chesney** has joined Winterset Medical Associates in the family practice of medicine. A 1974 graduate of U. of I. College of Medicine, Dr. Chesney interned at Maricopa County General Hospital in Phoenix, Arizona.

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**Dr. Ali Safdar, Dr. Abdur Rehman Najam,** and **Dr. Nisoruddin Khan** have joined the staff at the Mental Health Institute in Independence. Dr. Safdar received the M.D. degree in Pakistan and took postgraduate training at Memorial Medical Center at Niagara Falls, New York. Dr. Abdur Rehman Najam received the M.D. degree in Pakistan and served his residency at Great Plains Mental Health Clinic in North Platte, Nebraska. Dr. Nisoruddin Khan received his medical education in India and is serving his residency in psychiatry at the Mental Health Institute. . . . **Dr. Dale Harding,** Eagle Grove, has been named president of Iowa Heart Association; **Dr. J. P. Long,** Iowa City, president-elect; and **Dr. H. E. Rudersdorf,** Sioux City, secretary. . . . **Dr. D. B. Blume** is new president of St. Luke's Medical Center medical staff; **Dr. E. M. Mumford,** vice president; and **Dr. M. R. Kolberg,** secretary-treasurer. All are Sioux City physicians. . . . **Dr. Richard M. Caplan,** associate dean for continuing medical education at U. of I. College of Medicine, has received a special fellowship to attend a month long seminar on "medical ethics" at Williams College in Williamstown, Mass. The competitive fellowships are awarded by the National Endowment for the Humanities to physicians and others in the health care professions. . . . **Dr. John E. Evans** concluded his medical practice in Winterset in June and has assumed a full-time staff position in the outpatient section of Veterans Administration Hospital in Des Moines.

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At meeting of staff of Mental Health Institute in Cherokee, **Dr. E. A. Kjenaas** was named chief of staff; **Dr. Chule H. Auh,** president; **Dr. Thomas Lucas,** vice president; and **Dr. James Duggan** (D.O.), secretary. . . . **Dr. Horst Blume,** Sioux City, has been appointed clinical associate professor in department of neurosurgery at University of South Dakota School of Medicine.

---

**Dr. A. B. Carstensen,** an IMS life member, was honored recently at an open house recognizing his 50 years of medical service to the citizens of Linn Grove. . . . **Dr. Thomas Rosenberger** has joined **Dr. Peter Wallace** in the practice of pedi-

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atrics in Iowa City. Dr. Rosenberger is a graduate of the University of Cincinnati Medical School. He interned and took his pediatrics residency at University Hospitals. He is a clinical assistant professor of pediatrics at U. of I. . . . **Dr. Carl H. Matthey,** Bettendorf, has been awarded lifetime membership in the alumni association of Washington University School of Medicine. The honor marked Dr. Matthey's 50th anniversary of his graduation from medical school. . . . **Dr. William Bliss,** Ames, was keynote speaker at a recent Emergency Medical Service Symposium (EMS) at Marshalltown Area Community Hospital West. Dr. Bliss currently serves as chairman of the Governor's EMS Advisory Council. . . . **Dr. Leo A. Gaukel** was honored recently for 42 years of continuous service to Onawa and the surrounding area. . . . **Dr. Paul D. Boone,** formerly of Paullina, has joined **Dr. Ivan E. Brown** to practice at the Hartley Medical Center. Prior to locating in Paullina in 1968, Dr. Boone served as assistant surgeon and house physician at St. Francis Memorial Hospital in Sacramento, California. . . . **Dr. John D. Conner,** Nevada, retired from active practice July 1. Dr. Conner received the M.D. degree at U. of I. College of Medicine and began his practice in Nevada in 1938.

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**Dr. Richard M. Ratino,** obstetrician and gynecologist, and **Dr. Peter M. Poor,** urologist, began the practice of their specialties in Sioux City in July. Dr. Ratino joined **Drs. Melvin Kelberg** and **Leonard Boggs** and Dr. Poor joined **Drs. Dwayne Howard** and **Robert Boldus.** Dr. Ratino received the M.D. degree at Creighton University in Omaha, Nebraska, and Dr. Poor received the M.D. degree at Western Reserve University in Cleveland, Ohio. . . . **Dr. G. E. Larson,** Elk Horn, was guest speaker at recent Iowa Western Community College LPN commencement. . . . **Dr. C. D. Fenton,** retired Bloomfield physician, was honored at Davis County Fair for his 40 years of medical service in the county. Dr. Fenton received the M.D. degree at U. of I. College of Medicine in 1931 and located in Bloomfield in 1932. . . . **Dr. Jerry Miller,** former Clarinda surgeon, has re-located in Shenandoah. Dr. Miller received the M.D. degree at University of Nebraska School of Medicine and served his internship and residency at Lincoln VA Hospital. . . . **Dr. L. A. Utterback,** D.O., Perry, was honored

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Mailing Address: Elmwood Station, Box 6076, Omaha, Nebraska 68106

at a recent open house commemorating his 45 years of medical practice. Dr. Utterback is currently chief of staff at Dallas County Hospital. . . . **Dr. Keith R. Hughet** established a psychiatric practice in Decorah in August. A 1951 graduate of U. of I. College of Medicine, Dr. Hughet interned and completed his residency in general surgery at Metropolitan Hospital of Kuyahoga County in Cleveland, Ohio, and his residency in psychiatry at Medical College of Wisconsin. A faculty member since 1973 of the Medical College of Wisconsin, Marquette University, Dr. Hughet will provide part time psychiatric consultation to the Northeast Iowa Mental Health Center, the Winneshiek County Care Facility and the Allamakee County Care Facility. . . . **Dr. Richard B. Wyatt** became associated in July with **Dr. James Habermann** in the pathology department at Trinity Regional Hospital in Fort Dodge. Dr. Wyatt received the M.D. degree at U. of I. College of Medicine and completed his residency at University Hospitals. . . . **Dr. John Graether,** a Marshalltown ophthalmic surgeon, conducted an advanced seminar in phaco-emulsification in Kansas City in July.

## DEATHS

**Dr. L. E. O'Connor,** 44, Emmetsburg, died July 20 at St. Mary's Hospital in Rochester, Minnesota. Dr. O'Connor received the M.D. degree at U. of I. College of Medicine in 1963. He had practiced medicine in Emmetsburg since 1965.

**Dr. John K. Stewart,** 66, pathologist at Jane Lamb Hospital in Clinton for 35 years, died at his home July 17. Dr. Stewart received the M.D. degree at Indiana University Medical School and completed his internship and residency at University of Wisconsin in Madison, Wisconsin, where he served as an instructor.

**Dr. John C. McKitterick,** 78, Burlington pediatrician, died at University Hospitals in Iowa City on July 28. Dr. McKitterick received the M.D. degree at Washington University College of Medicine in St. Louis, Missouri. He had practiced in Burlington since 1922. Dr. McKitterick was a life member of IMS; past president of Des Moines County Medical Society, Iowa Pediatric Society, Family Service Agency of Burlington and Des Moines County Chapter, National Foundation for Infantile Paralysis, and was a licentiate of American Board of Pediatrics.


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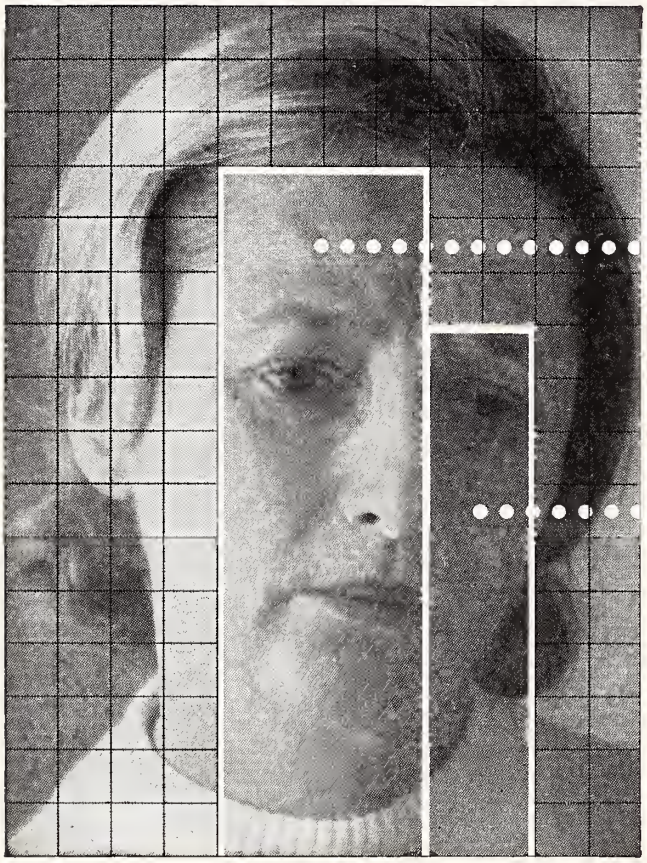
# Both often

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anxiety states
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depressive symptoms

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# President's Page

I have always thought of October as World Series month. But it's now also "Immunization Action Month."

The year 1975 will be the third for a nationwide focus on immunization and the need for it. Special emphasis is again on 1-4 year old children and their need for protection against polio, measles, mumps, rubella, diphtheria, pertussis and tetanus.

Immunization levels of our preschool children were declining prior to 1974. As a response, October was designated "Immunization Action Month." The objective is to stimulate parents to complete the immunizations of their children. Additionally, IAM serves to remind physicians' offices of the need to complete patient immunization records.

The 1973 and 1974 IAM efforts have helped to increase the immunization levels of preschool children. Obviously, we must maintain surveillance and inform and educate parents regarding the value of immunizations. As physicians, we must review our records regularly to see that our young patients are immunized.

In addition to the youngsters, I believe it is important for those patients with chronic respiratory disease, especially an obstructive lung disease, to receive full preventive care from respiratory infections. When possible, these patients should receive viral immunizations every year.

I believe also those persons who by their work are constantly exposed to viral respiratory infections should receive immunizations or boosters.

*Remember, do your part in Immunization Action Month.*

Sincerely,

V. L. Schlaser MD

*V. L. Schlaser, President*

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# IOWA Medical Miscellany

**PSRO VOTE FAVORS IFMC . . .** Over 1,600 Iowa physicians voted in support of the Iowa Foundation for Medical Care in August poll re PSRO. A 63% margin of the voting physicians favored the IFMC; 51% was needed for the IFMC to qualify for PSRO designation. The August 29 vote tally cleared the way for IFMC designation as the conditional Professional Standards Review Organization. Negotiations with HEW are now in process.

**PRESENTS LIABILITY STATEMENT . . .** C. H. Denser, Jr., M.D., presented a 15-minute statement for the IMS at the September 9 first meeting of the Medical Liability Interim Study Committee of the Iowa General Assembly. Dr. Denser is IMS Medico-Legal Chairman. Society statement urged total effort to find permanent solutions and offered full support of IMS. Committee is meeting in October and November.

**SEND GUIDELINES . . .** IMS booklet containing guidelines and procedures for accreditation of continuing medical education programs has been sent to chiefs of medical staffs of Iowa hospitals. Institutions and facilities offering CME programs may achieve AMA accreditation status by meeting stipulations set forth in the IMS booklet. The program has been endorsed by the IMS House of Delegates.

**CURRENT STATUS . . .** Reports from Iowa anesthesiologists indicate theirs continues to be the most precarious area for medical liability coverage. Anesthesiology coverage problems (some of which have been resolved) have been reported recently in Cedar Rapids, Dubuque, Waterloo, Des Moines and Sioux City.

**SPECIAL OCTOBER EVENTS . . .** On Wednesday, October 15, special fall conference for county medical society presidents (or their designees) will be held at IMS headquarters. Important conference topics will include consideration of PSRO, professional liability, health planning and continuing medical education. On preceding day, October 14, also at IMS headquarters, a seminar for new members is planned to acquaint those attending with the structure and programs of the Iowa Medical Society.

**EVENTS CALENDAR . . .** The preceding two events and other highlights of the 1975-76 IMS year are contained in a printed folder which has been distributed to Society members.

**DISTRIBUTE PLAN . . .** The 330-plus page Comprehensive Health Plan for the State of Iowa was sent September 12 by the IMS to presidents of county medical societies. The plan was recently approved by the Governor's Advisory Committee/Office for Comprehensive Health Planning. The broad and dynamic plan contains sections on emergency medical services, acute care services, long term services, public health services, health manpower resources and several other subject areas. An explanatory letter from J. E. Tyrrell, M.D., chairman of the OCHP Advisory Committee, accompanies the plan.

**OFFICER VISITS . . .** Approximately a dozen county medical societies have indicated a desire for an IMS officer to visit them and present a report during the fall or winter. This response has come from an IMS request to share current information at county society meetings. Additional opportunities are being sought.

*(Please turn to page 425)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 10
OCTOBER 1975

## TABLE OF CONTENTS

### SCIENTIFIC SECTION

Hypercalcemia and Its Prognostic Implications in Chronic Myelogenous Leukemia —A Case Report
Zarina Rasheed, M.D., Richard F. Looker, M.D., and Kingsley B. Grant, M.D. . . 423

Fluid Resuscitation of Burn Patients Comparing a Crystalloid With a Colloid Containing Solution: A Prospective Study
Pablo R. Recinos, M.D., Charles A. Hartford, M.D., and Sidney E. Ziffren, M.D. . 426

### EDITORIALS

Chubby Cherubs . . . . . 433

Where Am I? How Are Things Going? . . 434

### SPECIAL DEPARTMENTS

President's Page . . . . . 416

Iowa Medical Miscellany . . . . . 417

The Question Box
IFMC and PSRO Program . . . . . 419

State Department of Health
Iowa Immunization Action Month . . . 420

In the Public Interest
The Iowa Malpractice Situation—A Crisis? 435

Educationally Speaking . . . . . 437

Medical Assistants . . . . . 438

About Iowa Physicians . . . . . 441

Deaths . . . . . 443

### MISCELLANEOUS

Continuing Education Courses and Conferences . . . . . 437

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# The Question Box

by KENNETH E. LISTER, M.D.

## STATUS OF IFMC/PSRO

*As president of the Iowa Foundation for Medical Care, Dr. Lister comments on recent developments with respect to the IFMC and the PSRO program.*

**In recent weeks, the Foundation has received backing from the profession to pursue conditional designation as the Professional Standards Review Organization. What comment do you have regarding the polling process?**

We believe it is imperative that any organization administering PSRO be representative of area physicians. The polling process was good in that it allowed for a confirmation of the representativeness of the Foundation. Over 50% of the Iowa physicians needed to affirm the IFMC in the recent poll. More than 63% did. Certainly, the fact that over 2,600 ballots were cast illustrates the interest of Iowa physicians. We believe all physicians, no matter how they voted, should now seek to fully understand PSRO and be assured the IFMC will work constructively to insure its effective administration.

**Obviously, there is substantial apprehension among Iowa physicians over PSRO. What is the Foundation's response to this apprehension?**

To a greater or lesser degree, we are all apprehensive about PSRO. It is new and controversial and suggests further bureaucratic complexity. We think the Foundation represents the physicians' best approach to making the law work to the good advantage of the profession and its patients. We hope that as familiarity with the Foundation's approach to PSRO increases, some of the apprehension will diminish. It is especially important for physicians to understand PSRO and to take part in its development. Participation is the key to understanding. Such participation will result in dividends for the Foundation as it pursues a broad peer review program in behalf of the medical profession.

**What appears to be the PSRO timetable in Iowa?**

The Foundation hopes by mid-October to have achieved official PSRO status. We hope to begin developing working relationships with hospitals shortly after our designation. This fall we will devote much time to organizational structure, staffing and educational effort.

**Summarize briefly again the anticipated role of the IFMC in the performance of PSRO functions?**

Officially, PSRO's are responsible for evaluating the appropriateness and quality of medical care rendered. This is expected to be done in two ways. Foremost is the Foundation's commitment to support local review where it is effective. Where a hospital medical staff is limited in its capability or desire to perform local peer review, it will become the Foundation's responsibility to establish an acceptable system. In either instance, it will be the local physicians who have responsibility for assuring implementation of the law.

# State Department of Health

## IOWA IMMUNIZATION ACTION MONTH

October is Immunization Action Month in Iowa and throughout the country. Immunization Action Month (IAM) is a month-long educational program designed to encourage complete immunization of infants and pre-school children against diphtheria, pertussis, tetanus, poliomyelitis, mumps, rubeola and rubella. Nationally, this effort is coordinated by the Center for Disease Control in Atlanta, Georgia, while in Iowa it is spearheaded by the Immunization Action Advisory Committee and the Iowa State Department of Health. Each year, IAM in Iowa has been initiated by proclamation of Governor Robert D. Ray. The Iowa Medical Society, the Iowa Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians, and the Iowa Association of Osteopathic Physicians and Surgeons are actively represented on Iowa's Immunization Action Advisory Committee.

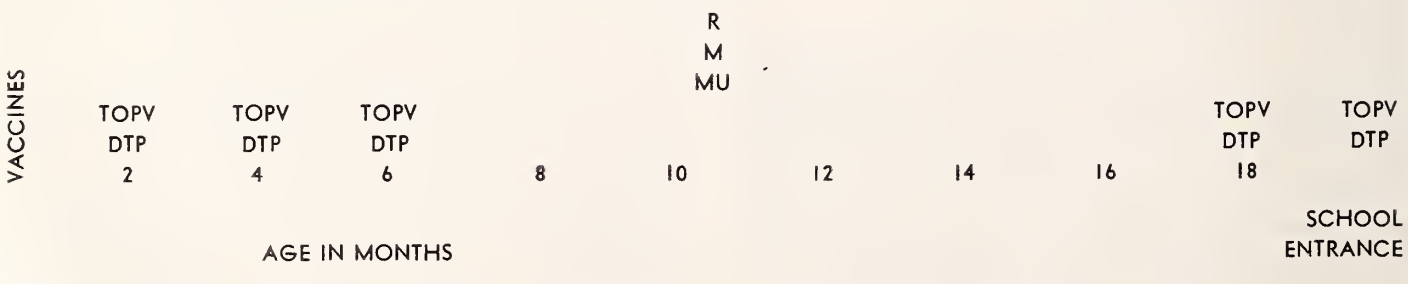
The two major activities of IAM are immunization recall and public and professional education, and both have the support of the House of Delegates of the Iowa Medical Society. They are significant parts of an overall effort designed to make Iowa the "First State to Eradicate" those diseases for which immunizing agents are available.

"Immunization recall" urges all immunizing facilities (i.e. doctors' offices, public clinics, schools, etc.) to review past records of children to find those who have received fewer than the recommended number of immunizations and to contact the parents of those children, urging them to complete the full program. Several Iowa physicians have already instituted a chronological file system for such recall.

Public and professional immunization education will receive priority during October. County medical societies and other physician groups are urged to critically review immunization activities at meetings during the month. Radio, television and newspapers have been given immunization materials and asked to utilize them in news and public service features during October. The Iowa Pharmaceutical Association, the Iowa P.T.A. and auxiliaries of the Iowa Medical Society and the Association of Osteopathic Physicians and Surgeons are assisting with widespread distribution of posters, pamphlets and other educational items.

IAM is an annual opportunity for public and private health care providers to jointly urge Iowa parents to take advantage of the protection read-

### Recommended Ideal Childhood Immunization Schedule Summary




*Legend*
TOPV—Trivalent Oral Polio; DTP—Diphtheria, Tetanus, Pertussis; M—Measles; MU—Mumps; R—Rubella

ily available to their children through preventive vaccines. This may be among the most significant efforts directed to the protection of good health for all Iowa children.

The current "Recommended Immunization Schedule for Iowa" of the Iowa State Department of Health is provided for the reference use of Iowa physicians.

## Recommended Immunization Schedule for Iowa

The following is a compromise of the recommendations of the American Academy of Pediatrics and the Public Health Service Advisory Committee on Immunization Practices.

A. FOR CHILDREN 0-18 YEARS OF AGE

| *Immunizing Biological* | *Best Time to Give* | *Number of Doses* | *Boosters* |
|---|---|---|---|
| DIPHTHERIA & TETANUS TOXOIDS PERTUSSIS VACCINE (DTP) | Start at 2 months (not recommended after age 6—use TD) | 3 injections 2 months apart | 1 year later and at school entrance. Subsequent boosters of Diphtheria-Tetanus (for Adult Use) (TD) at 10 year intervals. See below |
| TETANUS & DIPHTHERIA TOXOIDS, COMBINED (TD) (For use over age 6) | 6 years and over (use DTP if younger than 6 years) | 2 injections 4 to 6 weeks apart. (If not previously immunized with DTP) | 1 year after first series of DT or DTP, then at 10 year intervals. Begin 10 year interval with latest dose. No booster for wound generally needed if last dose within 5 years. |
| TRIVALENT ORAL POLIOVIRUS VACCINE, LIVE (TOPV) (Sabin) | Start at 2 months<br>If started at age 1 year or older | 3 oral doses 8 weeks apart.<br>2 oral doses 8 weeks apart. | 1 dose of TOPV 1 year later and again at school entry. No further boosters presently considered necessary. |
| MEASLES VACCINE, LIVE VIRUS FURTHER ATTENUATED (without gamma globulin) | After 12 months | 1 injection | Not presently considered necessary. |
| RUBELLA VACCINE LIVE VIRUS | After 12 months, with caution after puberty | 1 injection | Not presently considered necessary. |
| MUMPS VIRUS VACCINE, LIVE | After 12 months | 1 injection | Not presently considered necessary. |
| MEASLES & RUBELLA VIRUS VACCINE, LIVE (Combination vaccine) | After 12 months, with caution after puberty | 1 injection | Not presently considered necessary. |
| MEASLES, MUMPS & RUBELLA VIRUS VACCINE, LIVE (Combination vaccine) | After 12 months, with caution after puberty | 1 injection | Not presently considered necessary. |
| SMALLPOX VACCINE | Routine non-selective smallpox vaccination of children is no longer indicated or recommended in Iowa. Smallpox is no longer a threat in Iowa. (See under B below.) | | |

INTERRUPTION OF SCHEDULE

Interruption of the recommended schedule, by longer than the recommended time between doses, *does not* necessitate starting the series over again.

B. FOR ADULTS

*TETANUS*—The original series is two 0.5cc injections, intramuscularly, at four to eight week intervals, followed by a third dose about a year after the second. To maintain protection, boosters should be given at ten-year intervals. If wounding occurs within five years of booster, another booster may be indicated if the wound is considered likely to be tetanus contaminated. Begin new ten-year booster interval from date of any booster.

*DIPHTHERIA*—Use only toxoids labeled "for adult use." Tetanus-Diphtheria Toxoids, combined (for adult use) is the agent of choice, administered according to above outlined schedule for tetanus.

*POLIOMYELITIS*—Adults need this immunization only when traveling abroad or should an epidemic occur. Follow the schedule for children over one year of age.

*INFLUENZA*—Annual immunization with latest available preparations is recommended for all persons over age 65 or who have chronic debilitating conditions. Local priority may justify immunization of other persons who provide essential community service.

*TYPHOID*—Routine typhoid immunization is NOT recommended in the U.S. There are no data to support typhoid vaccine use before attendance at summer camps or in flood situations. Inti-

mate and continuous contact with a typhoid carrier or travel to areas where typhoid is endemic are indications for typhoid vaccination. The primary series is two 0.5cc doses given subcutaneously at intervals of four or more weeks. A booster dose of 0.5cc may be given every three years. Use of vaccine containing Paratyphoid A and B antigens is NOT recommended.

*SMALLPOX*—Medical and hospital personnel, morticians and others likely to be exposed to smallpox imported in the United States should be vaccinated at 3 to 5 year intervals. Travelers to and from continents where smallpox has not been eradicated should be vaccinated. Except when exposure to smallpox is highly likely and cannot be avoided, the following CONTRINDICATIONS to vaccination should be scrupulously observed: (1) Eczema and other forms of dermatitis in the person to be vaccinated or in a household contact (2) pregnancy (3) altered immune states from disease or therapy.

### C. AREA COVERED BY THESE RECOMMENDATIONS

The immunizations as reported here are those recommended for Iowans in Iowa. With few exceptions, such as the need for Rocky Mountain Spotted Fever vaccine for persons whose work may take them to certain areas, these recommendations are adequate for the entire United States. Other immunizations may be needed for travel outside of the United States. Information on these may be obtained by requesting our sheet, "Immunizations for Overseas Travel."

### D. SIMULTANEOUS ADMINISTRATION OF VACCINES

DTP and TOPV have traditionally been given simultaneously. Among the live virus vaccines, measles, mumps, and rubella vaccines may safely and effectively be given simultaneously; and TOPV may safely and effectively be given simultaneously with the measles/mumps/rubella combination vaccine.

# Morbidity Report for August, 1975

| Disease | August 1975 | 1975 to Date | 1974 to Date | Most August Cases Reported From These Counties |
|---|---|---|---|---|
| Amebiasis | 1 | 13 | 26 | Johnson |
| Ascariasis | 1 | 8 | 9 | Muscatine |
| Brucellosis | 1 | 12 | 12 | Linn |
| Chickenpox | 27 | 6642 | 6192 | Crawford, Dubuque, Jones, Scott |
| Conjunctivitis | 30 | 886 | 529 | Clinton, Johnson, Linn, Polk |
| Encephalitis | | | | |
| Viral | 1 | 3 | 13 | Henry |
| ECHO 4 | 1 | 2 | 3 | Polk |
| Erythema infectiosum | 6 | 138 | 513 | Buchanan, Scott |
| Gastrointestinal viral inf. | 94 | 14784 | 5627 | Chickasaw, Davis, Jackson, Johnson |
| Giardiasis | 4 | 12 | 35 | Dubuque, Marion, Polk |
| Hepatitis, A (Infectious) | 10 | 108 | 198 | Benton, Floyd, Iowa, Linn, Polk |
| Hepatitis, B (Serum) | 11 | 69 | 63 | Adair, Dallas, Fayette, Marshall, Polk |
| Hepatitis, type unspecified | 1 | 24 | 24 | Harrison |
| Impetigo | 42 | 368 | 198 | Benton, Jackson, Madison, Webster |
| Infectious Mononucleosis | 16 | 814 | 642 | Buena Vista, Johnson, Mills, Polk, Scott |
| Influenza-like illness | 96 | 36222 | 89447 | Buena Vista, Chickasaw, Dallas, Worth |
| Meningitis | | | | |
| *H. influenza* | 2 | 12 | | Muscatine, Scott |
| *Pneumococcal* | 1 | 2 | 2 | Black Hawk |
| *B. hemolytic strep* | 1 | 1 | | Jackson |
| Type unspecified | 2 | 26 | 27 | Buchanan, Des Moines |
| Meningoencephalitis | 1 | 2 | | Buena Vista |
| Mumps | 7 | 1001 | 1617 | Delaware, Monroe, Polk, Scott |
| Pediculosis | 10 | 215 | | Delaware, Dubuque, Scott |
| Pinworms | 10 | 34 | 41 | Polk |
| Pneumonia | 37 | 762 | 632 | Scattered |
| Rabies in Animals | 10 | 80 | 98 | Scattered |
| Rubeola | 14 | 589 | | Clinton, Dubuque, Polk |
| Salmonellosis | 36 | 135 | 125 | Scattered |
| Scabies | 25 | 283 | 60 | Davis, Dubuque, Linn, Polk |
| Shigellosis | 10 | 51 | 188 | Cass, Dubuque, Polk, Poweshiek, Woodbury |
| Streptococcal infections | 243 | 6933 | 2793 | Johnson, Marshall, Muscatine, Polk |
| Trichuriasis | 1 | 3 | 2 | Hamilton |
| Tuberculosis, total ill | 4 | 80 | | Black Hawk, Jefferson, Mills, Woodbury |
| Typhoid Fever | 1 | 1 | | Poweshiek |
| Venereal Diseases | | | | |
| Gonorrhea | 668 | 4436 | 3982 | Black Hawk, Johnson, Linn, Polk, Scott |
| Syphilis | 25 | 200 | 268 | Scattered |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | |
|---|---|---|---|
| Cytomegalovirus | 4 | Enteropathogenic *E. coli* | 1 |
| Eaton's agent | 1 | Herpes simplex | 9 |
| ECHO 4 | 1 | Herpes zoster | 1 |

SCIENTIFIC SESSION

# Hypercalcemia and Its Prognostic Implications in Chronic Myelogenous Leukemia—A Case Report

ZARINA RASHEED, M.D.,
RICHARD F. LOOKER, M.D., and
KINGSLEY B. GRANT, M.D.
Cedar Rapids

*Hypercalcemia associated with chronic myelogenous leukemia was first described in 1970. This report describes such a condition accompanied by widespread metastatic calcification. The probable pathophysiology of hypercalcemia, its prognostic importance and untoward complications are reviewed.*

THE ASSOCIATION of hypercalcemia with malignant diseases has been well documented.[1-6] In recent years this metabolic abnormality has been noted in acute leukemias[7-10, 14, 15] and, more rarely, in chronic lymphocytic leukemia.[11-13] (The frequency of this disorder in the latter disease is not yet documented.)

The occurrence of hypercalcemia in association with chronic myelogenous leukemia was first reported by Ballard and Marcus in 1970.[16] Only 2 other reports[17, 18] have been published since then.

The purpose of this paper is to describe another case of chronic myelogenous leukemia with terminal hypercalcemia (accompanied by generalized metastatic calcification) and to stress the prognostic implications of this finding.

Drs. Grant and Looker are associated with the Department of Pathology at St. Luke's Methodist Hospital in Cedar Rapids, Iowa. Dr. Rasheed was at St. Luke's when this paper was prepared and is now located in Freeport, Illinois.

## CASE REPORT

A 64-year-old man was admitted to St. Luke's Methodist Hospital (Cedar Rapids) on October 21, 1970, complaining of weakness and weight loss of about 6 months duration. Physical examination revealed hepatosplenomegaly (with the spleen palpable 6 cm below the costal margin). Laboratory examination: Hgb 11.0 gm; Hct 29.5 vol%; WBC count 472,000 with 97% granulocytes (39 of these granulocytes were myeloblasts, promyelocytes, myelocytes or metamyelocytes, 25% bands and 33% segmented polymorphonuclear leukocytes). Platelet count was 650,000/cu mm. Bone marrow aspirate revealed marked hypercellularity, mostly composed of myelocytes, metamyelocytes and occasional myeloblasts. Uric acid was 11 mg%.

A diagnosis of chronic myelogenous leukemia

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF OCTOBER, 1975.

Figure 1. Section of the ileum showing leukemic infiltrations.

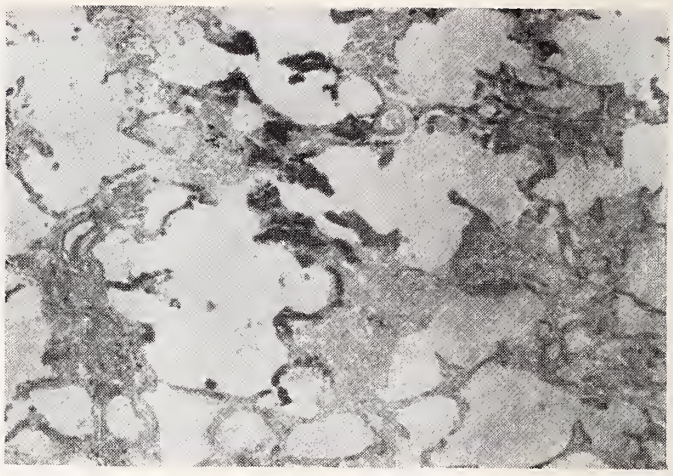


Figure 2. Section of the lung showing calcium deposits within the alveolar walls.

was made and Busulphan therapy was initiated and maintained on an out-patient basis. In December 1971, the patient was re-admitted because of severe malaise and pain in the sternum and left hip. Hgb was 16.6 gm, Hct 55%. The WBC were 105,000 with 12% bands and 59% segmented polymorphonuclear leukocytes. There were metamyelocytes, myelocytes and promyelocytes in the peripheral blood. Urinalysis was normal. The platelet count was 66,000/cu mm. Terminally, the WBC count was 113,000 with a normal differential except for 5 immature forms, and the platelet count was 14,000/cu mm. X-rays of the left hip showed degenerative and osteoporotic changes.

There was gradual improvement in the patient's chest x-rays during the following 2-3 weeks. However, he became weak, depressed and stuporous. At this time hypercalcemia was first detected with a serum calcium level of 15 mg%. He was given large doses of Prednisone. The serum calcium level was reduced but the uremia persisted. He died suddenly on January 24, 1972.

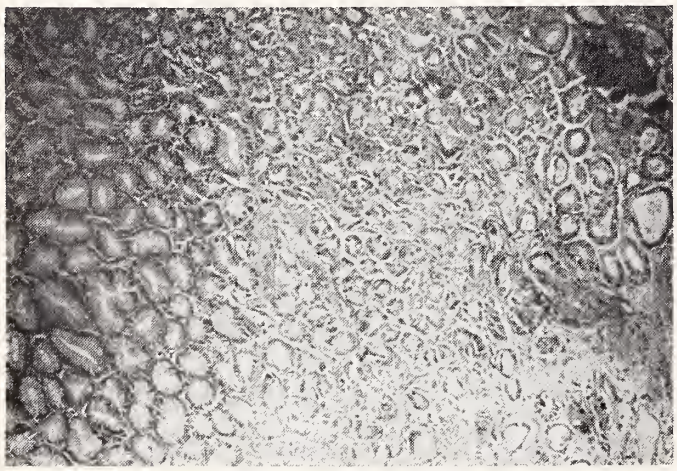


Figure 3. Section of the gastric mucosa showing interglandular calcification.

At autopsy, massive leukemic infiltration of the bone marrow (Figure 1) and widespread metastatic calcification were present. Calcium deposits were found in the lungs and especially in the alveolar walls (Figure 2). The myocardium contained focal calcification. Calcium deposits were also found in the interglandular stroma of the gastric mucosa (Figure 3), in the area corresponding to the location of acid secreting cells, as described in a previous report.[21] Kidney calcification was found in the lumen of the proximal and distal renal tubules and also in the basement membrane of the glomeruli. There was no selective localization in the cortex or the medulla. The pancreas, thyroid and prostate glands also showed metastatic calcification.

## DISCUSSION

The appearance of hypercalcemia in chronic myelogenous leukemia is ominous. It signifies a poor survival rate and is seen either in the terminal phase of the illness, as in this case, or just before the onset of a 'blastic crisis.[20]

The reason for hypercalcemia in malignancies in general, and particularly in leukemia, is not well understood. One of the most accepted theories is that this metabolic disorder is due to release of large amounts of calcium from bone undergoing rapid destruction[19] (regardless of etiology), with calcium salts in the form of phosphates and/or carbonates escaping into the blood and with subsequent deposition in tissues in an alkaline state, e.g. lungs, kidneys, and, in the case of gastric mucosa, following the secretion of acid.

One mechanism suggested for the development of hypercalcemia, particularly in leukemia, is that leukemic infiltration of the parathyroid gland in-

duces increased parathyroid activity.[19] However, in most autopsied cases of chronic granulocytic leukemia, the parathyroid glands were found to be normal.

Gordon, *et al*,[23] proposed another mechanism in which an osteolytic vitamin D-like sterol, rather than a parahormone-like substance, is secreted by malignant cells and accounts for increased serum calcium levels (e.g. in mammary cancers).

Chabler and Haskel[20] described 6 cases of chronic granulocytic leukemia with osteolytic lesions. In 3 of the cases bone involvement occurred during the 'blastic phase of leukemia, and in 2 the bone lesions were the initial manifestation of 'blastic transformation. The abrupt onset of localized severe bone pain should raise suspicion of an osteolytic lesion in patients with this disease. Butler[11] postulates the use of cortisone to control the osteolytic lesions of bone is successful probably because cortisone decreases the absorption of calcium from the gastrointestinal tract and increases the urinary output of calcium.

Another possibility that needs to be explored is that the leukemic cells may be capable of producing a hormonal substance, which can cause osteolytic lesions.[6] However, there is no evidence at present that such a substance is synthesized by these cells, and the entire pathophysiology of hypercalcemia, with or without metastatic calcification, in chronic granulocytic leukemia is subject to further elucidation.

The deposition of calcium salts in viable tissue is triggered by supersaturation of the serum with calcium and phosphate ions; alkaline pH of the tissues; increased phosphatase activity; and probable tissue injury due to initial calcific changes.

This case and other recent published reports[17-19] re-emphasize that hypercalcemia should be included with other criteria of fever, lymphadenopathy, etc.[24] in evaluating the course of chronic myelogenous leukemia. While some of the criteria may be helpful, they are not always and uniformly present before the onset of a crisis. On the other hand, the occurrence of hypercalcemia invariably signifies impending rapid deterioration. Therefore, we strongly recommend that calcium levels should be closely monitored in all patients with chronic granulocytic leukemia for an early prognostication of an approaching 'blastic transformation or death.

We gratefully acknowledge Dr. William Galbraith's assistance in making the clinical records available to us. We also owe our thanks to Ms. Judy Meskel for her technical assistance in preparing the manuscript.

## REFERENCES

The references noted in this article are available either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

## IOWA MEDICAL MISCELLANY

*(Continued from page 417)*

**NORTH CENTRAL PARLEY . . .** K. E. Lister, M.D., Ottumwa, will preside at the North Central Medical Conference set for November 1 and 2 in St. Paul, Minnesota. NCMC includes Iowa, Nebraska, Minnesota, North and South Dakotas.

**ROSTER IN PROCESS . . .** A new IMS Membership Roster is now being prepared for distribution to member physicians. It is expected to be ready in late October or early November.

**CME PROGRAM . . .** Special medical and surgical lecture series at Des Moines Veterans Hospital will continue through October with presentations on Wednesdays, Thursdays and Fridays. More information is available from joint sponsors, University of Iowa and Des Moines VA Hospital.

**M&CH . . .** IMS Committee on Maternal and Child Health met October 1 with T. D. Scurletis, M.D., new director of the Division of Maternal and Child Health of the Iowa State Department of Health.

**AMA-CPT USE . . .** Recent random sample of claim reports evaluated by Blue Shield showed that 51% were pre-coded with the five-digit AMA-CPT number. This practice has been encouraged by the IMS.

**CHILD ABUSE . . .** A regional child abuse and neglect center is to be established at The University of Iowa with a three-year, $750,000 grant from the National Institute of Child Health and Human Development. Emphasis will be on supportive services to professionals who work in rural and semi-rural communities. Gerald Solomons, M.D., professor of pediatrics, will be acting director.

# Fluid Resuscitation of Burn Patients Comparing A Crystalloid With a Colloid Containing Solution: A Prospective Study

PABLO R. RECINOS, M.D.,
CHARLES A. HARTFORD, M.D.,
and
SIDNEY E. ZIFFREN, M.D.

*Evaluation is made of two different solutions used for fluid resuscitation of burn patients. Reduction in fluid related morbidity but not mortality was observed among patients treated with colloid containing crystalloid when compared with crystalloid alone.*

It is generally accepted that fluid containing sodium is required to prevent or resuscitate patients from burn shock. There is controversy about whether colloids are needed or even helpful. The only published alternate case prospective clinical study done in an attempt to answer this basic question was conducted in Peru during the 1950's and 1960's.[2, 3, 6-8]

At the University of Iowa Hospitals, between 1950 and 1960, the mortality during the first week after injury, arbitrarily designated as the acute phase, for patients with greater than 10% body surface area of burn (SAB) was 31%.[4] In the 6 year period ending December 1970, during which lactated Ringer's solution was used almost exclusively as the resuscitative fluid for patients with burns, the mortality during the first week for those with greater than 10% SAB was reduced to 12%. However, during this 6 year period there was not a progressive decline in the acute phase mortality in spite of the fact that during the last 2 years of this period a Burn Unit was established and the patients received more intense care.

To determine whether acute phase morbidity and mortality could be reduced by employing a colloid containing fluid we initiated a prospective clinical study comparing lactated Ringer's solution (LR) alone with a solution composed of 25 gm of albumin in lactated Ringer's solution, a 2.3% albumin solution, (LR+A).* The latter solution was chosen because Hoyle, *et al.*, found that dogs subjected to a full thickness scald of two-thirds of the body surface required one-third less fluid, excreted twice as much urine, gained one-half as much weight, and recovered and maintained significantly higher glomerular filtration rates when resuscitated with LR+A as compared with those treated with LR alone.[5]

## MATERIAL AND METHOD

Patients with 30% SAB or greater who arrived in the Burn Unit less than 12 hours after injury, regardless of age and regardless of whether or not fluids were given prior to admission were included. Which test fluid the patient received was determined by hospital number. The fluid was administered intravenously at a rapid rate until urine flow was established, then given at a rate to attempt to maintain an output of urine between 30-50 ml/hour for adults, corresponding but lesser amounts for children. Urine output is a highly regarded variable used to monitor the fluid resuscitation of burned patients. No predetermined formula for calculation of fluid was used. The regimen was continued for a minimum of 48 hours

Dr. Recinos is a former resident, Department of Surgery, University of Iowa College of Medicine. He is now in private practice in Mason City. Dr. Hartford is an associate professor in the Department of Surgery, University of Iowa College of Medicine, and Director of the Burn Unit. Dr. Ziffren is professor and chief, Department of Surgery, University of Iowa College of Medicine.

* The LR used contains per 1,000 ml, 135 mEq of sodium, 4 mEq of potassium, 2.7 mEq of calcium, 109.7 mEq of chloride and 27 mEq of lactate. The LR+A was made by adding 25 gm of salt poor albumin in 100 ml to 1,000 ml LR, giving 1,100 ml of a 2.3% albumin solution which contains an average of 148.5 mEq of sodium.

unless death occurred or a complication supervened which justified a change in fluid management. All patients had nothing by mouth for the first 48 hours after admission. The use of $NaHCO_3$, mannitol, furosemide and digitalis was left to the discretion of the physician in attendance. Many laboratory studies were obtained periodically throughout the period of administration of the test fluid. The results of these tests will not be analyzed in this report. The burn was dressed with dressings continuously wet with 0.5% silver nitrate.[9]

There are 29 patients (Table I) in this study 15 treated with LR and 14 treated with LR+A. For analysis, the patients were further divided by age into 3 groups. There were no patients under the age of 2 years. Group 1, (2-12 years of age) 10 patients, 6 treated with LR and 4 treated with LR+A; Group 2, (13-59 years of age) 15 patients, 6 treated with LR alone and 9 treated with LR+A; Group 3, (60 years of age and older) 4 patients, 3 treated with LR alone and 1 treated with LR+A.

TABLE I

| | Patients | % Burn Avg | Deaths Acute | Deaths Chronic | Morbidity Acute Phase |
|---|---|---|---|---|---|
| Group I, 2-12 years of age | | | | | |
| LR | 6 | 40 | 0 | 1 | 1 |
| LR+A | 4 | 77 | 1* | 1 | 0 |
| Group II, 13-59 years of age | | | | | |
| LR | 6 | 54 | 1* | 1 | 3 |
| LR+A | 9 | 57 | 1* | 1 | 0 |
| Group III, 60 years of age and older | | | | | |
| LR | 3 | 63 | 3 | — | — |
| LR+A | 1 | 82 | 1† | — | — |

* Inhalation injury.
† Myocardial infarction.

## RESULTS

The pertinent data for all 29 patients is tabulated in Tables IIA and IIB.

## VOLUME OF FLUID

Children (Group 1) received more fluid of either kind for successful resuscitation than did adults (Group 2). During the first 24 hours after

TABLE II-A

PATIENTS TREATED WITH LACTATED RINGER'S SOLUTION

| Case No | Age Yrs | Wgt Kg | Burn % | First 24 Hrs. Vol ml/kg/% | Na mEq/kg/% | Alb gm/kg/% | Urine ml/hr | Diuretics | Result of Rx | Acute Phase Related Complications |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 15.4 | 30 | 5.8 | 0.79 | — | 42.0 | 0 | Survived | None |
| 2 | 4 | 16.7 | 60 | 5.0 | 0.67 | — | 16.1 | 0 | Died Sepsis 20 days | None |
| 3 | 2 | 11.6 | 47 | 5.2 | 0.70 | — | 22.6 | 0 | Survived | None |
| 4 | 8 | 25.9 | 40 | 4.6 | 0.63 | — | 37.5 | 0 | Survived | None |
| 5 | 12 | 36.3 | 38 | 5.2 | 0.70 | — | 38.2 | 0 | Survived | None |
| 6 | 2 | 12.5 | 30 | † | † | | † | X | Survived | Renal failure, pulmonary edema, Rx changed at 22 hrs |
| 7 | 21 | 67.1 | 32 | 2.6 | 0.35 | — | 63.5 | 0 | Survived | None |
| 8 | 59 | | 90 | * | * | — | * | X | Died resp. burn 16 hrs | Urine out 12.9 ml/hr 1st 12 hrs |
| 9 | 27 | 75.7 | 35 | 4.9 | 0.67 | — | 21.9 | X | Survived | Upper airway obstruction |
| 10 | 31 | 91.8 | 71 | 3.0 | 0.40 | — | 31.8 | 0 | Died sepsis 15 days | Bilateral pleural effusion |
| 11 | 49 | 91.0 | 60 | 1.7 | 0.23 | — | 33.8 | 0 | Survived | None |
| 12 | 31 | 96.8 | 37 | 2.5 | 0.34 | — | 42.0 | X | Survived | Severe vasospasm of unburned legs with necrosis of toes |
| 13 | 87 | | 71 | † | † | | † | X | Died 8 days | Urine out 16.8 ml/hr 1st 12.. hrs Rx changed.. |
| 14 | 85 | | 71 | * | * | | * | X | Died burn shock 7 hrs | Oliguria, 8.3 ml/hr for 7 hrs |
| 15 | 60 | | 46 | † | † | | † | X | Died renal and resp. failure 12 days | 25.1 ml/hr urine out 1st 18 hrs with 18,000 ml LR in (pulmonary edema) |

* Calculations not included because patient died prior to completion of study period.
† Calculations not included because inadequate fluid resuscitation and treatment changed before completion of study period.

TABLE II-B

PATIENTS TREATED WITH LACTATED RINGER'S SOLUTION PLUS ALBUMIN

| Case No | Age Yr | Wgt Kg | Burn % | First 24 Hrs. Vol ml/kg/% | Na mEq/kg/% | Alb gm/kg/% | Urine ml/hr | Diuretics | Result of Rx | Acute Phase Related Complications |
|---|---|---|---|---|---|---|---|---|---|---|
| 16 | 6 | 22.7 | 70 | 3.7 | 0.50 | 0.084 | 38.0 | 0 | Survived | None |
| 17 | 3 | 17.3 | 84 | 4.2 | 0.57 | 0.105 | 24.5 | 0 | Died 4 days pneumonia | ? resp. burn |
| 18 | 8 | 24.2 | 77 | 3.7 | 0.50 | 0.084 | 23.2 | 0 | Survived | None |
| 19 | 10 | 31.8 | 78 | 2.1 | 0.28 | 0.048 | 17.0 | 0 | Died 20 days sepsis | None |
| 20 | 13 | | 88 | * | * | * | * | X | Died 28 hrs resp. burn | |
| 21 | 40 | 88.3 | 57 | 2.1 | 0.28 | 0.048 | 44.6 | 0 | Survived | None |
| 22 | 26 | 70.4 | 56 | 1.5 | 0.20 | 0.034 | 70.8 | 0 | Survived | None |
| 23 | 31 | 80.3 | 31 | 1.1 | 0.15 | 0.025 | 55.1 | 0 | Survived | None |
| 24 | 39 | 92.9 | 50 | 1.6 | 0.22 | 0.036 | 38.8 | 0 | Died 21 days sepsis | None |
| 25 | 29 | 87.0 | 65 | 2.1 | 0.28 | 0.048 | 69.3 | 0 | Survived | None |
| 26 | 31 | 90.7 | 35 | 3.8 | 0.51 | 0.086 | 45.0 | 0 | Survived | None |
| 27 | 25 | 70.2 | 60 | 2.2 | 0.29 | 0.050 | 53.2 | 0 | Survived | None |
| 28 | 19 | 57.3 | 75 | 1.9 | 0.26 | 0.043 | 57.3 | 0 | Survived | None |
| 29 | 97 | | 82 | * | * | * | * | 0 | Died 34 hrs myocardial infarct | Respiratory distress |

* Calculations not included because patient died prior to completion of study period.

admission children received an average of 5.2 ml/kg/% SAB of LR whereas adults received an average of only 2.9 ml/kg/SAB (Table III). For LR+A children received 3.4 ml/kg/% SAB whereas adults received 2.0 ml/kg/% SAB. Using an appropriate analysis of variances, these differences are highly significant ($p = 0.001$).

TABLE III

VOLUME OF FLUID GIVEN IN FIRST 24 HOURS

| | ml/kg/% BURN | | | |
|---|---|---|---|---|
| | LR | | LR+A | |
| Group | Avg. | Range | Avg. | Range |
| I | 5.2 ml | 4.6-5.8 ml | 3.4 ml | 2.1-4.2 ml |
| II | 2.9 ml | 1.7-4.9 ml | 2.0 ml | 1.1-3.8 ml |

Among both children and adults who survived the first 48 hours and who did not have their fluid management altered because of the occurrence of a complication, those who received LR+A were given less fluid (Table III). Among the children, those receiving LR were given an average of 5.2 ml/kg/% SAB for the first 24 hours whereas those receiving LR+A were given an average of 3.4 ml/kg/% SAB for the same period. Among the adults the corresponding values are 2.9 ml/kg/% SAB for LR and 2.0 ml/kg/% SAB for LR+A. The difference in each set of values is highly significant ($p = 0.001$). The volumes of fluid given to those patients who died within 48 hours of admission or whose treatment had to be altered from that of the protocol are not included in these calculations. Also, the volumes of fluid received prior to admission to the study were not included. Although this is a valid criticism of this study, the volumes received were not sufficient to alter these calculations significantly. For both adults and children who survived resuscitation without having their fluid management altered because of the occurrences of a complication, the average amount of sodium given was one-third less when LR+A was used (Table IV).

TABLE IV

SODIUM GIVEN IN FIRST 24 HOURS mEq/kg/% BURN

| | LR (Average) | LR+A (Average) |
|---|---|---|
| Group I | 0.66 | 0.46 |
| Group II | 0.40 | 0.27 |

In Groups 1 and 2, among patients who did not die of inhalation injury, the attending physician thought it necessary to use diuretics during the first 48 hours in the treatment of 3 patients receiving LR but not in a single instance among

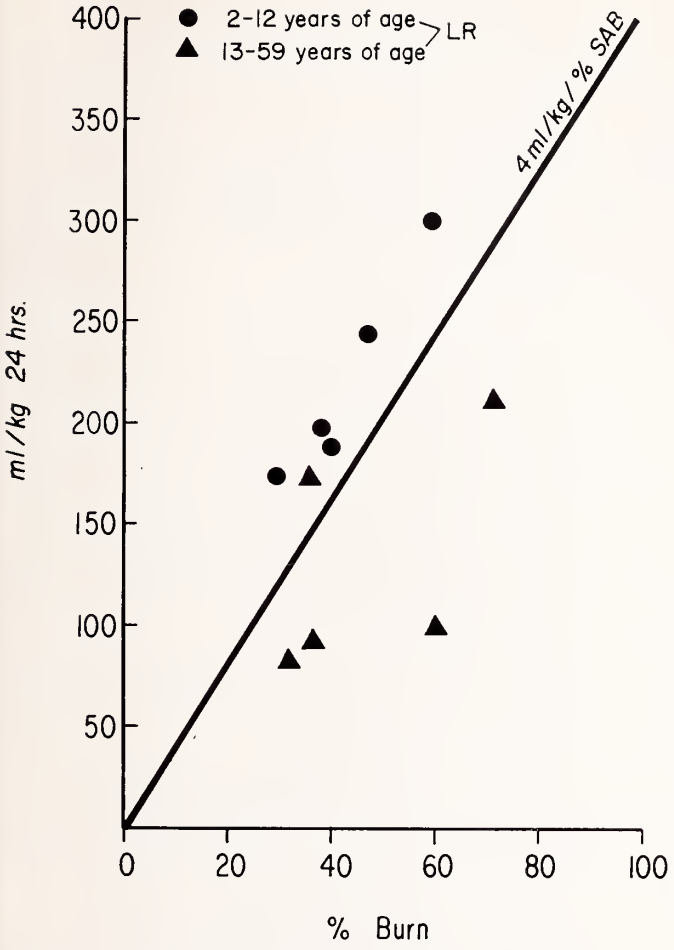



Figure 1. Volumes of lactated Ringer's solution given during first 24 hours. The diagonal line is that which would yield 4.0 ml/kg/% surface area burned, or the amount of fluid recommended by Baxter as a guide during the first 24 hours after injury.

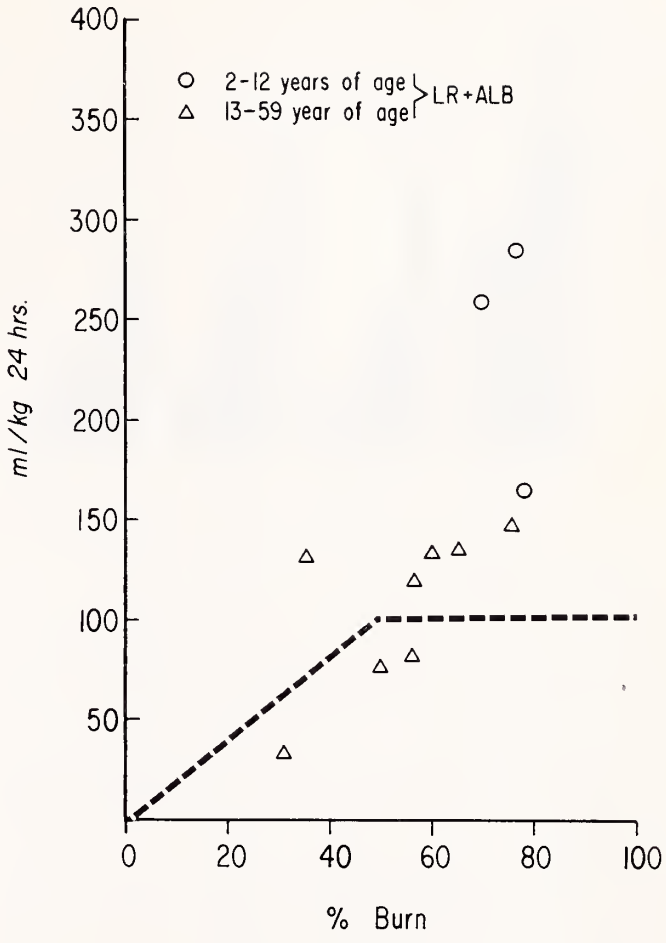



Figure 2. Volumes of lactated Ringer's solution plus albumin given during the first 24 hours. The dashed line is amount of colloid and electrolyte solutions predicted by the Evans and Brooke Formulae for the first 24 hours after injury.

those treated with LR+A. In addition, although an effort was made to keep urine flow rates in the range of 30-50 ml per hour for adults, urine flow was generally greater among those treated with LR+A. This is evidence that even lower volumes of LR+A are needed to resuscitate these patients safely.

Figure 1 shows the volume of LR given during the first 24 hours calculated as ml/kg body weight and plotted against % SAB. The diagonal line is that which gives 4.0 ml/kg/% SAB, or the amount of fluid recommended by Baxter[1] as a guide during the first 24 hours when LR is used alone. All the children who received LR alone were given more and all of the adults except one were given less than the amount of fluid that would have been derived from the calculation.

Figure 2 shows the volume of LR+A given during the first 24 hours calculated as ml/kg/% body weight and plotted against percent surface area involved by burn. The dashed line shows the predicted volume derived from the Brooke or Evans formula with the cutoff at 50% SAB; the volume of fluid recommended for daily maintenance is not included.[10] The volumes of LR+A given to the adults were parallel to the recommended guideline volumes for those with less than 50% SAB. There was, however, no cutoff seen at the 50% SAB level. All children who received LR+A had more than 50% SAB. The volumes given to these children were far above that recommended as guidelines for fluid replacement according to the Brooke and Evans formulae and increased linearly as the extent of injury increased.

There were 4 patients who had no full thickness burn. Three of these patients were adults and they were given by far the least volumes of fluid for successful resuscitation.

The cumulative rate of fluid administration calculated as ml/kg/% SAB averaged for each 12

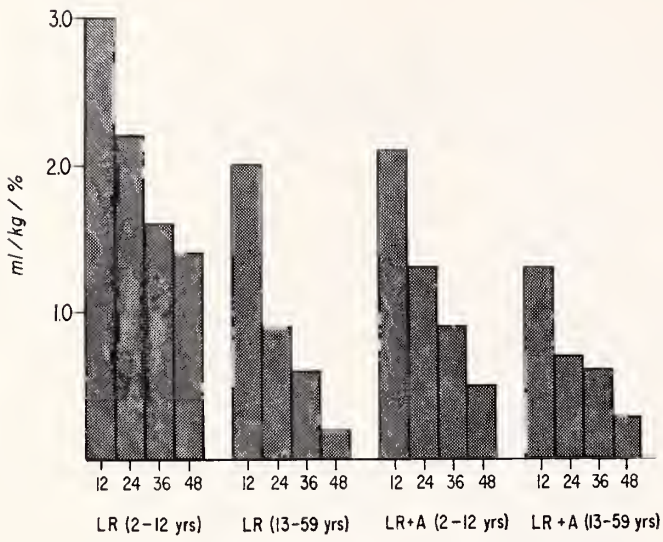



Figure 3. Volume of fluid given, averaged for each 12 hour period during the first 48 hours.

hour period during the first 48 hours for adults and children receiving LR and LR+A are shown in Figures 3 and 4. For all groups, the rate of fluid administration was greatest during the first 12 hours. Thereafter, less fluid was given during each 12 hour interval. For adults the volumes of fluid administered between the 36th and 48th hours after admission were less than that generally required for replacement of losses. This was not seen among the children; in fact, those treated with LR alone continued to receive almost as much fluid during the 36-48 hour interval as was given during the 24-36 hour interval.

## MORBIDITY

In Group 1 among the 4 patients treated with LR+A, one patient required an endotracheal tube because of the inhalation injury. This child died on the fourth postburn day and is not considered a failure of fluid resuscitation. Among the 6 children treated with LR there was one patient we judged to be a failure of treatment. This 2-year-old with a 30% SAB of full thickness from flame was admitted 2 hours after injury without having received any fluid prior to admission. During the first 22 hours after admission she received 7,000 ml LR or 18.6 ml/kg/% burn, gained 32.8% of her original body weight and had excreted only 175 ml of urine or 8.0 ml/hour. She had received several doses of mannitol and furosemide and had required an endotracheal tube. Five hours after admission, her urine specific gravity was 1.024 but it was 1.008, 22 hours after admission. The serum creatinine level rose from 1.1 mg%

*(Please turn to page 431)*

***IMPORTANT INFORMATION:*** *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

*Indications:* Lomotil is effective as adjunctive therapy in the management of diarrhea.

*Contraindications:* In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

*Warnings:* Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

*Usage in pregnancy:* Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

*Precautions:* Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

*Adverse reactions:* Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

*Dosage and administration:* ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

*Overdosage:* Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

*Dosage forms:* Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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455

on admission to 4.8 mg% on the third post burn day and subsequently declined. The therapy was changed 22 hours after admission. Eventually she survived.

Among the Group 2 patients treated with LR+A who did not die of inhalation injury, there were no acute phase related complications. However, among the 5 patients in Group 2 treated with LR and who did not have inhalation injury, there were 3 patients who had acute phase related complications; one patient required an endotracheal tube for upper airway obstruction caused by edema, one had bilateral pleural effusion requiring thoracentesis on the sixth day after the burn and one patient, a 31-year-old man with 31% SAB, developed severe vasospasm of his unburned legs which eventually resulted in necrosis of the tips of his toes. If these complications are accepted as related to fluid therapy there is a statistically significant difference ($p = 0.035$) in the complication rate among those patients ages 13-59 in favor of those treated with LR+A.

In Group 3, no patient survived acute phase related complications.

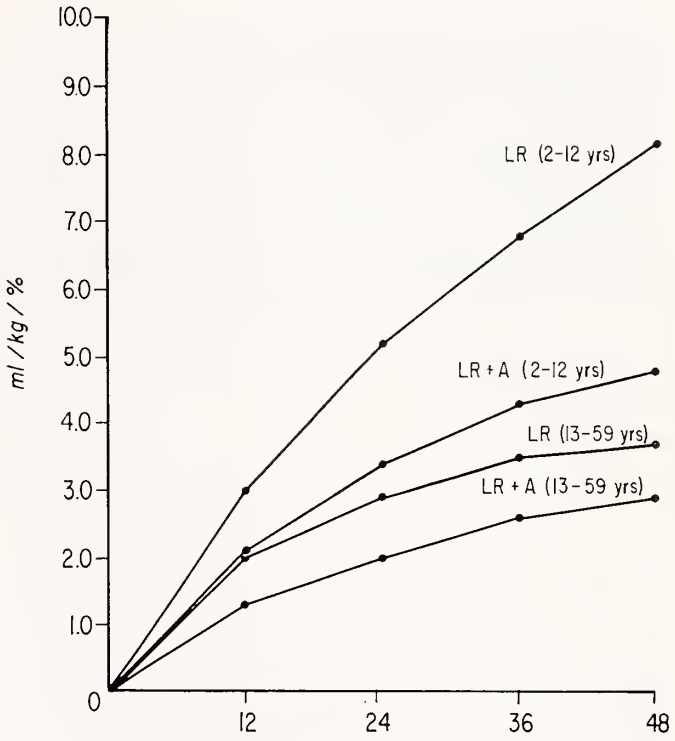


Figure 4. Averaged cumulative rate of fluid administration, during the first 48 hours.

## MORTALITY

In Group 1, 3 patients died, 1 treated with LR, of sepsis on the 20th day; and 2 treated with LR+A , 1 at 4 days, of inhalation injury and the other of sepsis on the 20th day.

In Group 2, 4 patients died, 2 treated with LR, 1 at 16 hours, of inhalation injury, the other on the 15th day, of sepsis; and 2 treated with LR+A, 1 at 28 hours of inhalation injury and the other on the 21st day, of sepsis.

In Group 3, all 4 patients died of acute phase related complications.

In regard to mortality, there is no statistically significant difference between those treated with LR and LR+A, either during the acute phase or subsequently.

## DISCUSSION

In the analysis of any study of fluid resuscitation of burned patients, mortality is the factor most highly regarded in determining differences in techniques. In this study of a small number of patients, even when those causes of death, myocardial infarct and inhalation injury, are excluded, there was no difference in acute phase or subsequent mortality. In the only prospective clinical study of a large number of patients attempting to solve this problem[2, 3, 6-8], it was concluded that among adults, late mortality was not influenced by the early fluid regimens studied; and among children, the addition of albumin to a balanced salt solution had no significant effect on mortality; whereas among children the addition of gamma globulin given intramuscularly to therapy with a balanced salt solution, the late mortality and the incidence of septicemia were lowered.

It is obvious there are many problems in conducting a prospective study of this kind. In a rural setting such as Iowa, patients must often travel great distances to our Burn Unit. There is therefore, in many instances, a delay in initiating fluid resuscitation. This will undoubtedly influence the success of resuscitation since the longer a patient is without fluid resuscitation the greater will be the degree of metabolic acidosis and the closer he is to renal failure. We thought this was a significant factor in a 60-year-old woman with a 46% burn who was not treated for 5.5 hours and who we could not effectively resuscitate. She died on the twelfth day after burn of renal and respiratory failure.

Although the mortality in this study was not influenced by initial fluid therapy, the complication rate was influenced among those 13-59 years of age. It is well known that complications beget complications and may eventually lead to death.

We therefore believe this is reason enough to conduct further prospective clinical analysis of fluid resuscitation techniques.

From this study, however, it is clear that children require more LR and more LR+A for successful resuscitation than do adults. Both children and adults require less fluid and less sodium for successful resuscitation when 2.3% albumin in LR is used than do those treated with LR alone.

Our data support the thesis that among adults, obligatory sequestration of fluid subsequent to thermal injury is over by 36 hours. Among children, however, between the 36th and 48th hour, they still required more fluid than is needed for maintenance plus losses, as judged from their urine output.

There are many factors which influence the volume of fluid required to resuscitate a burn patient successfully. Some of these factors are the composition of the fluid used, the source of heat causing the injury, the surface area burned, the depth of injury and the age, weight and preexisting medical condition of the patient.

The existing formulae for predicting volumes of fluid required for resuscitation of burn patients are only guides. In the use of these formulae only 2 dimensions are considered; weight of the patient and the extent of surface injured. Whereas, in fact, a burn has an additional dimension, i.e., depth of injury. This is usually not assessable at the time of injury. For instance, those adults in our study who had no full thickness burn following flame burn required the least amount of fluid. The 50% SAB cutoff point of the Brooke and Evans formulae for calculating fluid volumes are frequently exceeded in practice without producing complications related to fluid overload. These factors need to be publicized and might make a difference among individuals who have marginal renal and cardiopulmonary reserve and treated stringently according to any one of the accepted formulae techniques. Those in attendance must repeatedly assess the patient's clinical response to fluid therapy.

## SUMMARY

A prospective study comparing the efficacy of lactated Ringer's solution (LR) with LR with 2.3% albumin (LR+A) for fluid resuscitation of 29 acutely burned patients was done. Fluid was given intravenously at a rate to maintain a urine flow of between 30-50 ml/hour for adults, correspondingly less for children. No predetermined formula for calculation of fluid was used. For analysis the patients were divided by age into three groups: Group 1 (2-12 years), Group 2 (13-59 years) and Group 3 (60 years and older).

Children required significantly more of either kind of fluid for resuscitation than did adults. In both Groups 1 and 2, those treated with the colloid containing solution required significantly less fluid and less sodium for successful resuscitation. Although in all groups there was no difference in the acute phase (up to seven days after injury) or subsequent mortality among the adults of Group 2, there was a statistically significant difference in the complication rate in favor of those treated with LR+A. None of the patients in Group 3 survived acute phase related complications.

## REFERENCES

The references noted in this article are available on request from either the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

## INDEX TO ADVERTISERS

Burroughs Wellcome ..... 436
Geigy Pharmaceuticals ..... 418A, B
Lilly, Eli, & Co. ..... 413
Medical Protective Company ..... 442
Merck, Sharp, & Dohme ..... 430B, C, D
North Central Medical Conference ..... 440
Pharmaceutical Manufacturers Association ..... 422B, C
Prouty Company ..... 443
Robins, A. H., & Co. ..... 438A, B, 439
Roche Laboratories ..... 414-415, 447-448
Roerig, J. B., & Co. ..... 422A
Searle, G. D., & Co. ..... 430, 430A
Smith, Kline and French Laboratories ..... 422D

# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## CHUBBY CHERUBS

An exceptionally fat child who cannot trim down prior to 10 years of age faces dire consequences. He is destined to die sooner than his thinner friends, will have more illnesses than people of normal weight, and most surely continue to remain overweight all his shortened life. Experimental and clinical studies, as well as epidemiologic surveys, associate obesity and coronary artery disease. Infantile obesity is associated with adipose-cell hyperplasia, with the cells being the same size as an individual of normal weight, but two-to-three times greater in number. Long term studies, furthermore, have shown that once a weight range has become established it is very difficult to permanently disrupt its equilibrium. Fat babies are more likely to become obese adults; obese adults are more likely to have coronary artery disease.

It becomes obvious that the dietary regimen of infants has long-term implications. Their intake (quality as well as quantity) must be evaluated closely to avoid continuing trends that now indicate that about 5% of adults between 18 and 79 years of age have coronary artery disease—60% of these being under 65 years of age. Autopsy examinations of U. S. casualties of recent wars leaves little doubt as to the early onset of the pathologic process of atherosclerosis in young males. Fatty streaks begin to appear in the endothelium of the aorta by six months of age; these ultimately may develop into atherosclerotic plaques. Other intimal changes are commonly found in coronary arteries of infants and children. Much is yet to be learned in the basic area of the pathogenesis of atherosclerosis, but the evidence is strong that the precursors of this pathologic state may become established during childhood.

Various risk factors in adults may be present in children. These include evaluation of the serum cholesterol, obesity, hypertension, and lack of physical exercise. The hereditary factors, of course, have substantial bearing on all these factors. Cholesterol concentration in the serum is considered a very reliable predictor for the development of coronary artery disease. Triglyceride levels should be correlated with the cholesterol levels. The significance of higher levels in children requires further evaluation, but recommendations have come forth that all children under 5 years in families with histories of hyperlipoproteinemia and early coronary artery disease should have evaluations of serum cholesterol and triglycerides. High risk children, then, should be placed on appropriate diets and followed closely.

In addition to the prevention of obesity and the maintenance of normal serum lipid levels, it is incumbent the physician monitor the blood pressure of these young patients. Familial disposition to hypertension should be noted in pediatric patient histories. Note should also be made of familial impairment of glucose metabolism and proper studies should be made in this area.

Two more entities in the problem of atherosclerotic disease which have a very definite bearing in pediatric patients are: 1) cigarette smoking, and 2) lack of physical activity with high energy output. I need not dwell on the problem of smoking other than to decry its great prevalence among the pre-teens and teenagers as being a "smart" thing to do. Education campaigns must be continuous and forceful—not sporadic and weak.

Our modern way of life has decreased the energy output of today's children. Mothers serve as chauffeurs to and from school, to the drug store, and to the shopping centers to an extent

that it would seem the man of the future will lose the power of ambulation. Will it be mandatory for him to be carried eventually from one place to another by some new innovative form of transportation, elevators, escalators, cycles, or individual rocket-propelled means of locomotion? Further, our sources of entertainment tend to create more inactivity. Of course I refer to the television addiction of many children. To stimulate more activity it would seem wise to use the "out" method to keep children busy. This method consists of the parents pointing to the door and directing the child "out"—outside for play and other physical exercise.

A familiar advertisement of the past asked, "What's a mother to do?" If she wants to prevent her offspring from being a victim of coronary artery disease, she can watch his diet carefully, urge him to not smoke cigarettes, and turn off the TV. The physician can assist in ascertaining by a careful history the potential the child may have, do regular blood pressure determinations, insist on serum lipid studies on selected patients, and educate the parents as to the implications of the entire situation. Do not let the chubby cherub develop into another number among the mortality statistics of the incidence of coronary artery disease.—M.E.A.

## WHERE AM I? HOW ARE THINGS GOING?

Each of us desires to know our state of affairs. In the United States we are accustomed to the State of the Union message from the President. We are eager for the latest news. When we greet our friends we ask, "How are you?" Often the traveler must stop to inquire, "Where am I?" The businessman desires to know, "How am I doing?"

Assessment of one's life is necessary to survive as well as succeed. This does not mean economic success alone, but moral and emotional success as well. An initial assessment entails making a balance sheet of the assets, listing the objectives, and then determining how the assets can meet the objectives. The liabilities must be totaled into the entire assessment.

Professional life has many trials and tribulations. In our early years we learn many facts. We spend hours upon hours in classrooms, laboratories, and in the library to acquire as much knowledge as possible. Finally, on that happy day of graduation from medical college we are certain our knowledge of medicine surely exceeds that of any of our professors. Then, it is back to the studies for a varying number of years to develop further proficiency in a chosen field of medicine, be it family practice, surgery, or some exotic speciality. What constitutes post-graduate study? Is it more hours over the books? Is it long hours in the clinics and outpatient wards? Is it new IV's to start each day? Is it doing numerous histories and physicals?

I read a recent article about the plight of house officers burdened with scutwork; they were employees of the hospital rather than students. An attempt was being made to draw a line between service in a hospital for learning's sake and scutwork for the hospital's sake. It is a fine and truly difficult line to draw. Yet, even starting another IV can be a learning process because it is contact with the patient, serving the patient, and that is what medicine is all about. When the young (or old) physician divorces his attention from the patient, he does not serve the patient well. The individual in the hospital bed is still a person, though he may have an illness or be recuperating from a surgical procedure. Life itself is an educational experience. All our contacts with other humans are educational. In life with all its trials and tribulations there is scutwork to do.

Each and every student, be he a recent graduate or a practitioner of 25-30 years of service, must ask himself, "Where am I?" "How am I doing?" Do not fear to ask (and answer) these questions. Self assessment is good for the body and soul. No one is so great that he is immune to constructive criticism. The house officer may complain about the scutwork, we may complain about the paper work, but in the long run, isn't it for the patient?—M.E.A.

# THE IOWA MALPRACTICE SITUATION—A CRISIS?

*This feature is available free in folder form to IMS member physicians in quantities of 100 for distribution to patients. Please direct requests to IMS Headquarters.*

MEDICAL LIABILITY (or malpractice) is a term to which Iowans have been abundantly exposed in recent months. It's a subject of great complexity and extreme frustration.

In many states—and Iowa to a real extent—the medical liability situation is of crisis proportion. The impact of this crisis, it should be clearly understood, goes beyond physicians, hospitals and other health care providers. The impact is on the total Iowa patient population—and it could well increase in severity. Heavy boosts in liability insurance premiums to physicians—amounting in a few cases to 200 or more percent—must show up ultimately in the cost of patient care.

Public recognition of the situation is obvious. Nine of 10 persons in a 1975 Gallup Poll said they were aware of what's been called a national malpractice crisis.

*But understanding the crisis is the challenge. Where do you start?*

There are two basic horns to the dilemma:

- **The serious scarcity of liability insurance for Iowa physicians and hospitals.**
- **The skyrocketing cost of such insurance when it is available.**

Two factors contribute to the availability and cost problems. First is the seemingly unpredictable and continually increasing frequency of claims. Second is the mounting cost of these claims under the existing legal system.

Obviously, the costs cannot be increased indefinitely to the provider of health care (by the liability insurance company) and then to the consumer of medical services (by the physician or hospital). When the saturation point is reached society is confronted with an uninsurable risk. There is little logic in paying a $9,000 premium to insure a $10,000 object. When this point is reached—and some contend it is at hand—alternatives to or modifications in the present system have to be identified, considered and possibly implemented. Legislation containing alternatives is being pursued in nearly every state.

To its credit, Iowa has enacted a new law (House File 803) as a response to the dilemma. Few observers believe H.F. 803, which makes several changes in Iowa tort law, is more than a stepping stone to a more lasting solution. But it's given some incentive to the insurance companies. It's helped increase the availability of coverage even though what's available is expensive and restrictive in its upper limits. The situation is particularly acute in certain medical specialties, such as anesthesiology and neurosurgery.

It is most important, but not especially profound, to say that increased effort must be made to understand this subject—by the public, by the legislators, by the legal profession, and obviously, by the medical profession. Not many years ago, a medical malpractice suit was a rarity. Medical science of yesteryear was much more limited and adverse results of treatment were accepted as a fact of life. Now, a more litigation-conscious society regards good health as a product, to be dispensed foolproof by the physician. This is an impossibility. But, unfortunately, with many persons, the failure to realize full health has caused bitter disappointment with the results of treatment—and lawsuits have represented a way of resolving disappointment.

Nothing in the preceding is meant to suggest that medical accidents do not happen—but when they do today's legal system is believed by many to be slow and inequitable in its handling of those few who are the victims.

Implicit hopefully in these thoughts is the feeling of the Iowa medical profession that reason, fairness and the protection of rights must have priority status in dealing with the liability problem. Understanding of the subject, with resulting remedial action, depends heavily on factual and broad information, which has been lacking until just recently.

In the interest of all Iowans, we need to accelerate our efforts at every opportunity. A steady throttle must be applied by the Iowa General Assembly, the Iowa State Insurance Department, the insurance industry, the Iowa Medical Society and other concerned organizations. Behind this concentrated effort should be an interested and informed population.

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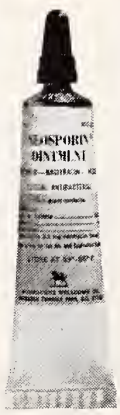

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# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## THE SAGE OF CONCORD

Today is my birthday. A third of a century ago, for my 13th birthday, an aunt gave me a book as a birthday present: *Emerson's Essays*. Perhaps it was meant as a compliment to an intelligent boy who liked to read. I suspect she never read it. I tried a few pages and found it totally unintelligible. My reaction was the expected one: I thought Emerson a stodgy bore (and his picture showed him to be very old) who was obviously not worth my bothering with. A dry sponge does not sense, I suspect, that with exposure to liquid it will become a much more efficient and useful sponge; that I was too dry a sponge to absorb well the fluidity of his writing and the profundity of his ideas was itself a notion that occurred to me only much later.

Last week I had the pleasant opportunity to visit Emerson's home in Concord, Massachusetts. The visit had the usual "museum-ish" characteristics and benefits—seeing the interior of such an old house (built about 1825), noting the old furniture style, the bedside washing basin and commode, the great many old books with faded and tattered bindings, the buckets hanging by the door to be grabbed when rushing off to fight a fire. But more important, there was present the vague sense of his presence, a man whose thoughts and words had such a great impact on America of his time and later.

A little pamphlet available there reviewed the story of Emerson's life and his varied contributions to the world of ideas, to literature, to other writers, to the maturation of American thought. In the pamphlet was this sentence: "Emerson once said that true youth is to be inquiring and ever to search for something new, to see inspiration all about." Maybe it's my years of working in continuing education that have made me appreciate a comment like that. Or maybe I've just made progress since my 13th birthday, so that I can now have better insight into what true youth means. In any event I see clearly now why Mr. Emerson came to be called The Sage of Concord.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

# Continuing Education Courses & Conferences

*Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.*

| | |
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| Oct. 3-4 | Dermatology for the Dermatologist |
| Oct. 3-4 | Reunion for Class of 1945 |
| Oct. 6-9 | Surgical Technique in Cleft Lip and Palate |
| Oct. 10-11 | Iowa Chapter of the American Academy of Ophthalmology and Otolaryngology |
| Oct. 13 | Cardiology Today |
| Oct. 17-18 | Current Trends in Psychiatry for the Psychiatrist |
| Oct. 18 | Breast Cancer Conference, Waterloo |
| Oct. 24-25 | Endocrinology Conference |
| Oct. 27 | Postgraduate Course for Physician's Assistant |
| Nov. 3-7 | Intensive Course in Pediatric Nutrition |
| Nov. 6-8 | Iowa Clinical Surgical Society |
| Nov. 7 | What's New in Stroke |
| Nov. 7-8 | Reunion for Class of 1950 |
| Nov. 13-15 | International Symposium on Cataract Operations and Their Sequelae |

# Medical Assistants

by TENORA MEYER, CMA

## INVITATION TO COUNCIL BLUFFS OCT. 19

Mrs. Donna Haney, CMA-AC, Education Chairman, Des Moines District, AAMA, State of Iowa, announces an October 19 seminar to be held at the Ramada Inn in Council Bluffs. The program will open at 9 a.m. with a 2-hour session on "Cardiopulmonary Resuscitation Instruction" led by the CPR instructor at Iowa Western Community College. Individual CPR instruction will follow.

At 1 p.m., Robert L. Pierson, M.D., will speak on "Cancer Research." He is head of the Department of Obstetrics and Gynecology at Creighton University. At 2 p.m., a program on "Adolescent Medicine" will be presented by Richard W. Hammer, M.D., Head of Student Health, University of Nebraska. The cancer review film, "The Embattled Cell," will be shown at 3 p.m., with an anatomy and physiology review from 3:30 p.m. to 4:30 p.m.

The educational fee for the meeting is $7 with luncheon at $3.50, for a total of $10.50. Reservations should be made by October 15 with Mrs. Donna Haney, CMA-AC, 330 S.E. Leach, Des Moines, Iowa 50315. The seminar is open to all medical assistants, regardless of AAMA membership.

## CPR

In relation to these seminar programs, Peary B. Berger, M.D., National AAMA Advisor, has made the following comments in the January-February 1975 issue of THE PROFESSIONAL MEDICAL ASSISTANT, referring to an article by Alice D. Furlong, CMA-A, in that issue entitled "The ABC's of Saving Lives": While medical assistants are required to work only under the direction of a medical doctor, the very job setting they work in requires a broad spectrum of basic medical knowledge." He urges every member, regardless of previous training and experience in CPR, to review the article by Ms. Furlong. In this article the following recommendations are made:

Medical Assistants in particular and the public in general should:

1. Know the signs and symptoms of cardiac arrest and respiratory inadequacy.
2. Study in detail the steps involved in cardiopulmonary resuscitation.
3. Take CPR courses given by certified instructors in accordance with American Heart Association standards. If these courses are not available in your community, encourage their formation.
4. Become aware of emergency care facilities in your area.
5. Encourage public interest in all of these.

CPR consists of opening and maintaining a patent airway, providing artificial ventilation by rescue breathing and providing artificial circulation by external cardiac compression.

As medical assistants, we are concerned particularly with basic life support and application of cardiopulmonary resuscitation including the following ABC's:

**A. Airway** } **Artificial**
**B. Breathing** } **Ventilation** } **Cardiopulmonary**
**C. Circulation—Artificial circulation** } **Resuscitation**

These steps should be started with a maximum sense of urgency as quickly as possible and performed in the order shown. Only seconds should intervene between recognizing the need and beginning CPR. Indications for basic life support are: (1) Respiratory arrest and (2) Cardiac arrest, resulting from cardiovascular collapse, ventricular fibrillation or ventricular standstill.

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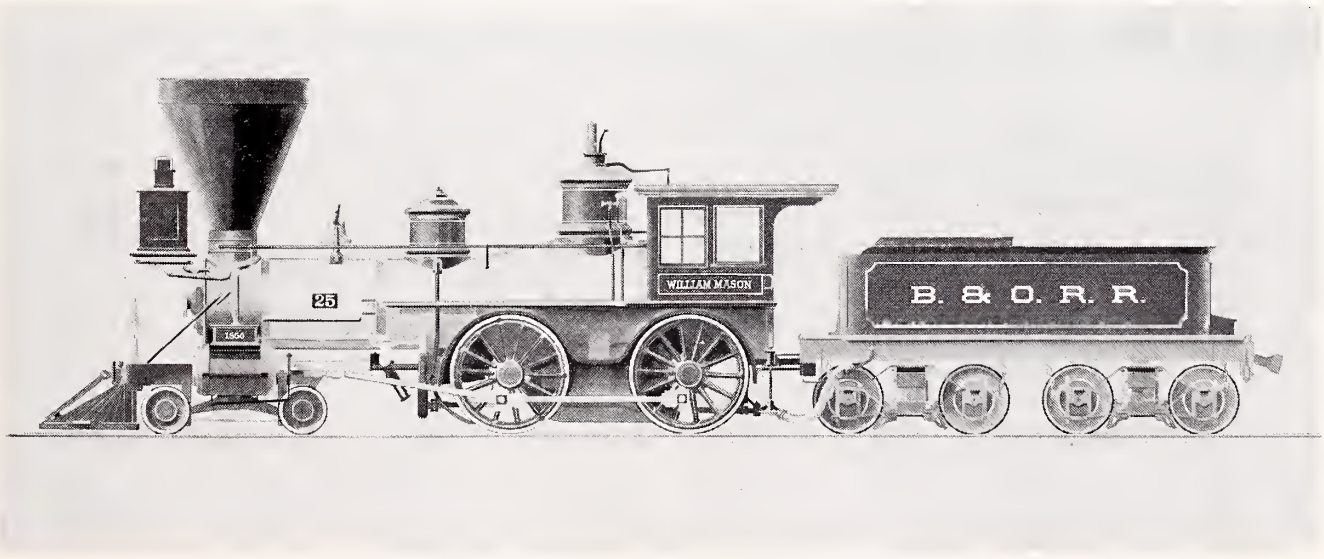


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# About IOWA Physicians

**Dr. Robert S. Brown,** formerly of Yakima, Washington, has opened an office for the practice of ophthalmology in West Des Moines, Iowa. Dr. Brown received the M.D. degree at U. of I. College of Medicine; interned at Butterworth Hospital in Grand Rapids, Michigan; and completed his residency at University Hospitals in Iowa City. Prior to entering private practice, Dr. Brown was assistant chief, USPHS Hospital, New Orleans, La.; member of attending staff in Department of Ophthalmology at Tulane University; and instructor in Department of Ophthalmology at University Hospitals in Iowa City. . . . **Dr. Alfred S. Karayusuf** has joined the staff of the Mental Health Center of North Iowa as medical director. Dr. Karayusuf received the M.D. degree at University of Minnesota and completed his residency in psychiatry at University of Minnesota Hospital.

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**Dr. Dwight E. Conklin** is new chief of staff at St. Francis Hospital in Waterloo. Other officers elected at recent annual meeting of St. Francis medical staff are—**Dr. Gilbert R. Clark,** vice president; and **Dr. David E. Brandt,** secretary. . . . **Dr. R. L. Barranda,** pediatrician, joined Medical Associates in Maquoketa in July. Dr. Barranda interned at St. Joseph's Hospital in Providence, Rhode Island, and also completed her residency in pediatrics plus a fellowship in child development and mental retardation and metabolic diseases at St. Joseph's. . . . **Dr. Jack M. Layton,** Cresco native, and current chairman of the Department of Pathology at University of Arizona Medical Center, has been elected president of the United States-Canada Division of the International Academy of Pathology. . . . **Dr. Anthony C. Catipay,** an obstetrician and gynecologist, has joined the Bluff Medical Center in Clinton. Dr. Catipay received the M.D. degree at University of Santo Tomas in Manila, Philippines, interned at St. Vincent Hospital and Medical Center in Toledo, Ohio, and completed his residency at Loyola University Medical Center in Chicago. . . . **Dr. Patrick Kain,** New Hampton, has been named an alternate member of the Health Systems Agency interim board. HSA will play a major part in health planning for 90 of Iowa's 99 counties. . . . **Dr. Pravey Itarut** began the practice of general medicine and surgery in Rock Rapids in August. Dr. Itarut received the M.D. degree at Shanghai University in Thailand; interned in Pittsburgh, Pa., and served his surgical residency at St. Francis Hospital in Denver, Colorado, and University Hospitals in Iowa City.

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**Dr. Fritz Viner,** son of **Dr. and Mrs. T. R. Viner,** Leon, has entered an otolaryngology residency at U. of I. College of Medicine. For the past year, Dr. Fritz Viner has been associated with his father in medical practice in Leon. . . . **Dr. Howard C. Bos,** Oskaloosa physician for 40 years, recently retired from medical practice. Dr. Bos and his wife moved to Florida in August. . . . **Dr. Ressurreccion L. Barranda** has joined Maquoketa's Medical Associates to practice pediatrics. Dr. Barranda interned at St. Joseph's Hospital in Providence, R. I., served her residency in pediatrics at Rhode Island Hospital in Providence; and fellowship in child development, mental retardation and metabolic diseases. . . . **Dr. Arthur A. Spector,** associate professor in Department of Internal Medicine at U. of I. College of Medicine, has been awarded a $15,950 research grant by the American Heart Association. Dr. Spector will use the funds to continue study of fatty acid binding of Ehrlich cells. . . . Keokuk County Hospital physicians recently elected **Dr. Larry Miller, II,** chief of staff and **Dr. M. Lee McClenahan,** chief of laboratory and co-ordinator of admissions. . . . **Dr. Loren L. Augustyn** has been

named director of Student Health Service at Iowa State University. A native of Nebraska and graduate of Creighton University Medical School, Dr. Augustyn has been in private practice and director of student health program at Kansas State College in Emporia.

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**Dr. Kenneth Olson,** who is completing his family practice residency at Mercy and St. Luke Hospitals in Cedar Rapids, will join **Drs. L. B. Bray** and **Bill Withers** at the Medical Clinic in Waukon on January 1, 1976. Dr. Olson worked briefly at the Clinic in the summer of 1974. . . . **Dr. Ray Miller,** Mason City, was guest speaker at August meeting of Wright County Medical Society in Belmond. Dr. Miller's topic "What's Available in Hand Surgery." For the first time in 10 years, the entire membership of the county medical society was present. . . . **Dr. Keith Garner** joined the Cherokee Clinic staff in July. Dr. Garner received the M.D. degree at University of Nebraska School of Medicine and formerly practiced family medicine in Franklin, Nebraska. . . . **Dr. Stanley M. Haugland,** Des Moines, chairman of IMS Committee on Alcoholism, was guest speaker at 12th annual alumni picnic of Alcohol-Drug Unit at Mental Health Institute in Independence. Dr. Haugland spoke on "Better Living, But Not Through Chemistry." . . . **Dr. B. W. Frommack** began a surgical practice in Pella in August. Dr. Frommack received the M.D. degree at U. of I. College of Medicine; interned at Sacramento County Hospital in California; and completed his residency in surgery at Veterans Administration Hospital in Long Beach, California. . . . **Dr. J. Scott Pennepacker,** Sioux City, has been appointed to the Task Force on Regionalization of the American Blood Commission.

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**Dr. James Gannon,** Laurens, has been appointed by Governor Robert Ray to State Board of Examiners for Nursing Home Administrators. . . . **Dr. Robert K. Mulert** has joined the Emergency Room staff at St. Luke's Hospital in Cedar Rapids. A native of Dubuque, Dr. Mulert received the M.D. degree at U. of I. College of Medicine and completed a one-year surgical residency at University of Utah in Salt Lake City. . . . **Dr. Gerald Solomons,** professor and head of Department of Pediatrics at U. of I. College of Medicine, was guest speaker at a recent Creston child abuse seminar. . . . **Dr. James W. Lannon** retired from medical practice in Mason City in August. Dr. Lannon received the M.D. degree at Creighton

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University School of Medicine, and began his medical practice in Mason City in 1946. . . . **Dr. Adrian J. Wolbrink,** orthopedic surgeon, recently joined the staff at Park Clinic in Mason City. Dr. Wolbrink received the M.D. degree at University of Minnesota; interned at Sioux Valley Hospital in Sioux Falls, South Dakota, and served in U. S. Public Health Service from 1966 to 1968. He completed his residency in orthopedic surgery at Mayo Clinic Graduate School and in 1972 was appointed chief resident associate to the staff. Following completion of his residency, Dr. Wolbrink served at the Kwangju Christian Hospital, Kwangju, Korea, as a medical missionary for the Presbyterian Church.

## DEATHS

**Dr. W. E. Walsh,** 73, West Union and Hawkeye physician, died August 11 at his home in Hawkeye. Dr. Walsh received the M.D. degree at Creighton University School of Medicine and began his medical practice in Hawkeye in 1930. A second office was opened in West Union in 1945.

**Dr. C. J. Ryan,** 67, Des Moines, died August 18 at Veterans Hospital in Des Moines. A graduate of U. of I. College of Medicine, Dr. Ryan began his medical practice in Creston and later moved to Clinton, where he practiced for several years before joining the medical staff at Veterans Hospital in Knoxville. Dr. Ryan retired in 1966.

**Dr. Clifford V. Bowers,** 63, Sioux City, died August 29 at his summer residence at West Lake Okoboji. Dr. Bowers received the M.D. degree at U. of I. College of Medicine in 1935 and completed his postgraduate work at Jersey Medical Center at Jersey City, New Jersey. From 1938 until 1943 Dr. Bowers practiced medicine in LeMars. He was a past president of Sioux City Lutheran Hospital medical staff and life member of University of Iowa Alumni Association.

**Dr. William N. Whitehouse,** 74, former Ottumwa physician, died September 8 in Columbus, Ohio. Dr. Whitehouse received the M.D. degree at U. of I. College of Medicine, interned at Denver General Hospital, Denver, Colorado, and served his residency in obstetrics and gynecology at Buffalo, New York. A commander in the Marine Corps, Dr. Whitehouse practiced medicine in Ottumwa for several years before entering military service.


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**EMERGENCY DEPARTMENT STAFF PHYSICIAN—455-bed hospital in suburban Omaha. One of five M.D.'s. New 14,000 sq. ft. department approved with construction to begin in Spring. Visits per month: 2500-3000. Hospital based specialists: neonatology, pulmonary disease, anesthesia, cardiology, pathology and radiology. Remuneration: $40-60,000 plus good fringes, depending upon experience. Experience in E. D. desired. Contact J. R. McCaslin, M.D., Director, Archbishop Bergan Mercy Hospital, Omaha, Nebraska 68124. 402/398-6031.**

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**EMERGENCY ROOM COVERAGE—Trauma Center, Cedar Rapids, Iowa. Established Emergency Room needs full time E.R. physician. Guarantee of $45,000 per year, on a rotating 42-hour week schedule. Additional fringe benefits are available through a professional corporation. Excellent staff specialists on call for specialized needs. Progressive city 25 miles from State University of Iowa medical school. Good recreational facilities. Excellent school system. Contact by telephone, or write to G. L. Schmit, M.D., Mercy Hospital, 701 10th Street, S. E., Cedar Rapids, Iowa 52403. 319/398-6037.**

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**ORTHOPEDIST, OB/GYN, GENERAL SURGEON wanted by expanding 24-man multi-specialty group in North Iowa. Fine family community of 32,000 actively serving needs of 300,000 area citizens. Close to Minneapolis and Des Moines via I-35. Eight miles to Clear Lake "Iowa's Vacation Capitol." Outstanding, progressive school system. Area college. Near Mayo Clinic and University of Minnesota. Good medical facilities. First year negotiated salary, then full partnership with modest investment. Generous time away benefits. Pension program. Each specialty represents addition to existing departments. Call collect AC 515/423-4120 for more information or mail curriculum vitae and request for Info Pack to Park Clinic, 116 N. Washington, Mason City, Iowa 50401.**

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**INTERNIST needed in Multispecialty group. Large new hospital with excellent facilities, liberal vacation, study time off. Iowa's newest city as a result of most successful urban renewal program—very progressive city—new tennis courts, indoor recreational facility and top quality schools. Call Ed Murphy, Clinic Manager, Carroll Medical Center, 502 North Court, Carroll, Iowa 51401.**

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**FAMILY PHYSICIAN URGENTLY NEEDED due to death of physician who had practiced in thriving northeast Iowa community for many years. County seat town. Option to buy. Contact the following for further details—Office of the late W. E. Walsh, M.D., 114 E. Elm Street, West Union, Iowa 52175, 319/422-3886 or Mrs. Helen Walsh, Hawkeye, Iowa 52147, 319/427-3212.**

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**PRIMARY CARE PHYSICIAN—Kansas State University Student Health Center and University Hospital anticipates an opening in its professional medical staff beginning October 1, 1975. The Center and Hospital is accreditated by the Joint Commission on Accreditation of Hospitals and includes a busy outpatient clinic, laboratory, diagnostic X-ray, mental health, pharmacy, physical medicine and 26-bed hospital. We are looking for an energetic primary care physician to join our medical staff of eight, with a supporting professional staff of seventy. Activity involves general practice with some office orthopedics, office gynecology, and office opthalmology. Office hours are 8-5 with on call schedule averaging 4-5 days per month. Salary range: $25,000-$30,000 depending on experience and qualification. Fringe benefits include one month vacation plus paid post-graduate education meetings. Experience in private medical practice is desired. Kansas State University is an equal opportunity employer. For further information please write Director, Lafene Student Health Center and University Hospital, Kansas State University, Manhattan, Kansas 66506.**

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**TWO FAMILY PRACTITIONERS in Northwest Iowa urgently seeking one or two associates in general practice. Opportunities unlimited. For more information phone 712/852-4203.**

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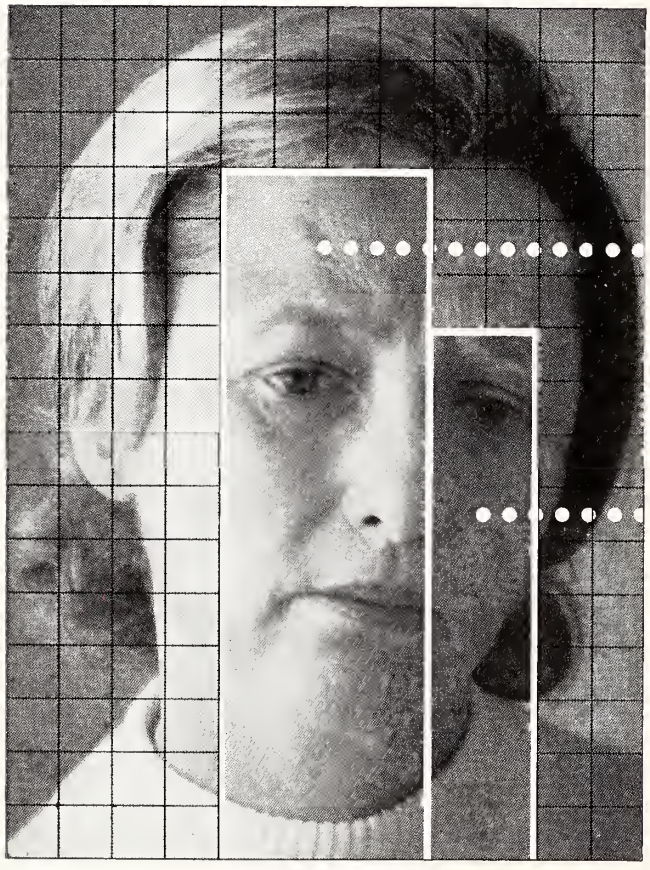


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in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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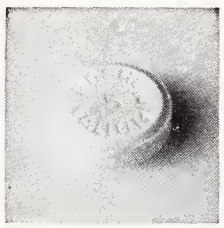

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in psychoneurotic
anxiety states
with associated
depressive symptoms

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ression, or with suicidal tendencies.
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# President's Page

In present day health care jargon, the terms primary, secondary and tertiary specify various levels of patient care.

In the early 1960's, primary care was that given by the first physician to see a patient in any episode of illness. Secondary care was thought of as that given by consulting physicians and/or care that required hospitalization. Tertiary care was that level of highly sophisticated treatment.

During the late 1960's and taken from the Millis Report of Graduate Medical Education, primary responsibilities became a concept correlated with primary care—thus developed the term comprehensive continuing care with the connotation that primary care also denotes primary responsibility.

In the early 1970's, the specialty of family practice developed and with the concept of primary responsibility, family practice residencies were established. Much was written and spoken within and outside medical circles about the public's need for comprehensive health care.

The American Academy of Family Practice has adopted a definition of the term primary care. It will undoubtedly stimulate discussion among legislators, educators, the public and the profession itself. It is as follows:

*"Primary care is a type of medical care delivery which emphasizes first contact care and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. It is personal care involving a unique interaction and communication between the patient and the physician. It is comprehensive in scope and includes the overall coordination of the care of the patient's health problems, be they biological, behavioral or social. The appropriate use of consultants and community resources is an important part of effective primary care."*

Sincerely,

V. L. Schlaser MD

*V. L. Schlaser, President*

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# IOWA Medical Miscellany

**FALL CONFERENCE . . .** Between 50 and 75 IMS members attended October 15 Fall Conference for County Medical Society Presidents. Held at Society Headquarters, the day-long session included panel discussions on professional liability, continuing medical education, health planning, etc.

**NEW MEMBER SEMINAR . . .** Approximately 20 physicians, newly affiliated with the Iowa Medical Society in the past 12 months, participated in a seminar October 14 at IMS Headquarters. Booklet entitled, "An Organizational Explanation of the Medical Profession in Iowa," was the basis for a portion of the program. Copies of the booklet are available on request.

**NAMED . . .** Marion E. Alberts, M.D., scientific editor of the IMS JOURNAL, has been named to a 5-year term on the Advisory Committee of the State Medical Journal Advertising Bureau, Inc. SMJAB represents approximately 30 state medical journals in the sales of advertising.

**HEALTH PLANNING . . .** The Health Systems Agency Interim Board for Iowa met 9/29 in Des Moines. Proposed articles and bylaws were accepted but are being withheld from distribution pending availability of HEW rules and regs. Next step in the formation process is a consortium meeting 11/17 with 1/1/76 set as date from submission of an application for HSA designation.

**MEMBERSHIP ROSTER . . .** New IMS Membership Roster is scheduled for mailing to Iowa physicians in November. Physician names in the roster are both alphabetical and geographical by county. Also included are members of the Auxiliary.

**FNP'S GRADUATE . . .** Six Iowans are among 23 nurses who recently graduated from the Family Nurse Practitioner Program at the University of North Dakota. IMS served as a co-sponsor of this experiment in health education with the Iowa Hospital Association. The students rotated between the ND campus and on-site indoctrination under supervision of a preceptor physician. The new Iowa FNP's are Annabelle Diehl, Osceola; Carla Freeman, Estherville; Vicky Krauth, Corning; Linda Ruble, Des Moines; Bethany Stephenson, Essex, and Joan Wenthworth, Preston.

**MALPRACTICE FOLDERS . . .** Several thousand copies of an IMS-prepared folder, "The Iowa Malpractice Situation—A Crisis?" have been requested by Society members. One hundred copies are available at no cost upon request.

**MEET WITH ANESTHESIOLOGISTS . . .** The IMS Executive Committee on Professional Liability met October 16 with representatives of the medical specialty groups most severely hit by the malpractice premium hikes. The session follows a 9/24 meeting of the IMS Board of Trustees with the anesthesiologists.

**AMA PUBLICATIONS . . .** JAMA and AMERICAN MEDICAL NEWS will now be the two publications distributed to AMA members as a membership benefit. Individual specialty journals and other publications will be on a subscription basis. This economy action is consistent with instructions from the AMA House of Delegates.

**1 IN 10 . . .** Preliminary data presented by the State Department of Health to the IMS Committee on Maternal and Child Health October 1 indicates that one of every 10 pregnancies in Iowa may be terminated.

*(Please turn to page 460)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 11
NOVEMBER 1975

## TABLE OF CONTENTS

The New Commitment Law
Selig M. Korson, M.D., F.A.P.A. . . . . 457

### SCIENTIFIC SECTION

High Pressure Injection Injuries to the Hand
William F. DeCesare, M.D., and B. L. Sprague, M.D. . . . . 461

Drug-Induced Anemia Associated With Glucose-6-Phosphate Dehydrogenase Deficiency
Fred Meister, Pharm.D., Lee Endsley, M.D., and Joseph D. Schmidt, M.D. . . . . 465

### EDITORIALS

Thanksgiving . . . . . 469

Ethics of Fetal Research . . . . . 470

### SPECIAL DEPARTMENTS

President's Page . . . . . 452

Iowa Medical Miscellany . . . . . 453

In the Public Interest
The Pursuit of Quality Care in Iowa . . 455

The Question Box . . . . . 456

Educationally Speaking . . . . . 471

State Department of Health
Human Hyperimmune Rabies Globulin Now Available As "Drug of Choice" . . 472

Medical Assistants . . . . . 474

About Iowa Physicians . . . . . 476

Deaths . . . . . 478

### MISCELLANEOUS

Continuing Education Courses and Conferences . . . . . 471

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# THE PURSUIT OF QUALITY CARE IN IOWA

*This feature is available in folder form to IMS member physicians. Please direct requests to IMS Headquarters.*

How do I know my doctor is competent? Can I be confident that what he tells me is based on a conscientious evaluation of my symptoms and my examination findings? He's so busy! He has so many patients.

*These questions occur to many Iowans.*

Individuals and families who've had long-standing association with a physician presumably feel confident they are being treated ably. But, with specialization prevalent in the delivery of medical care, many of us need the services of two, three or more doctors. The good of this should outweigh the impersonal factors which sometimes must increase in nature.

Just as you, one patient, are a separate and unique individual with distinct wants and needs, so is the next person. And the next. And the next. Similarly, your doctor has his mannerisms. He may be warm and understanding. He may be brisk and matter of fact.

Regardless of his personality, the competency of your doctor is subject to much professional scrutiny, in ways which are equal to or more stringent than those in any other of life's callings. His period of formal education exceeds most, his fulfillment of licensure requirements is a chore, his path to certification in a specialty (urology, pathology, etc.) is difficult. All this is as it should be for one dealing with a commodity as valuable as human life.

What does medicine do to keep its ranks in order? In the *Principles of Medical Ethics,* which serves the profession, this passage appears:

*"The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept all self-imposed discipline. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."*

In what organized manner do Iowa physicians maintain quality care? Various mechanisms exist to this end. The most important and widely recognized are (1) hospital medical staffs, (2) grievance committees (both at the county and state levels), (3) the Iowa Medical Society Judicial Council, (4) the Iowa Foundation for Medical Care, and (5) the State Board of Medical Examiners.

**Hospital Medical Staffs**—A most effective mechanism for assuring quality care is this local physician unit. Through committees on credentials, utilization review, etc., hospital staffs of physicians have a fundamental opportunity and responsibility to observe and control the work of their members.

**Grievance Committees**—These units exist in varying forms at the county level with the larger counties likely to be better organized. The basic task of a grievance committee is to resolve misunderstandings between patients and physicians. Complaints are received, investigated, and every attempt is made to resolve them. The Iowa Medical Society Grievance Committee functions when local attention is unavailable. It is also an appellate body.

**Judicial Council**—This 12-member body serves as the board of censors for the Iowa Medical Society. Final authority on membership in the Society rests with the Council. Expulsion from the Society, while a severe professional action, does not legally preclude a physician from practicing medicine.

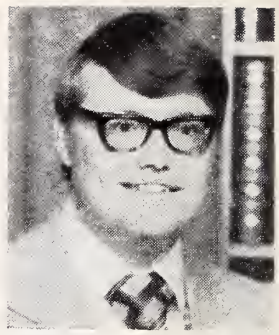
**Iowa Foundation for Medical Care**—The IFMC was created in 1971 by the medical profession. Its fundamental purpose is "to promote, develop, operate and organize peer review activities providing objectivity in dealing with health costs and utilization of services . . . to assure the public of optimum use of its health care resources."

**Board of Medical Examiners**—This Board has the force of law behind it. It determines the eligibility of applicants for licensure. It also investigates violations of the Medical Practice Act and conducts hearings to suspend or revoke licenses.

Instruments such as these are only as good as the people operating them. There is no denying this fact. It is the desire of the Iowa Medical Society to continue and strengthen these extremely important mechanisms.

# IN THE PUBLIC INTEREST

# The Question Box



by JOHN R. ADDY, M.D.

*Dr. John R. Addy has been in family practice in Boone for approximately one year. He was interviewed following his attendance at an October 14 seminar for new members held at IMS Headquarters.*

**The young physician is the profession's leader in the days ahead. Do you consider participation in the activities of medicine beyond your own practice worthy of what limited time you have?**

By all means. In order to keep current with events in the community, one has to be active in various community affairs. Non-medical activities offer an easy way to get acquainted in a community and they are certainly worthy of the physician's limited amount of time.

**Do you have any feeling as yet that the Iowa Medical Society is your organization?**

Yes. Dr. Ralph Wicks, our senior partner, was president of the Iowa Medical Society this past year. He kept us informed of all IMS activities and his role in the organization. Through his participation in the IMS and my association with him I have a definite feeling the Iowa Medical Society is my organization and should be for all physicians.

**Have you become more aware of what the IMS is all about?**

Yes, through the individuals introduced to us at the new member seminar. I was happy to become acquainted with the Commissioner of Public Health, Norman Pawlewski; meet our lobbyist, James West; hear from the president of Blue Cross, David Nugent, and learn about the Iowa Medical Society from Eldon Huston, our Executive Vice President. In addition, I found the remarks of Herman Smith, M.D., on the AMA at national level and the IMS on state level both interesting and informative. I was also happy to meet the staff and see the IMS Headquarters.

**In what ways do you think the Society could do a better job of reaching and serving new physician members?**

This is a very difficult question. I feel new physicians should be reached during medical school and residency years. The new practicing physician doesn't have much time during his "new years" to devote to outside activities. During these years he is busy building his practice, becoming acquainted with his new surroundings, and finding his role with his peers within his new community. The seminar afforded an excellent opportunity for new physicians to become familiar with the structure of the Iowa Medical Society and to meet some of the health care professionals in the state. However, a better attendance might be achieved if the conference were held for physicians in practice for five or six years. These physicians would be better established and might be able to devote more time to IMS activities which should be of interest to all physicians.

---

Iowa physicians who attended the IMS New Member Seminar were Drs. John R. Addy, Boone; Donald F. M. Bunce, II, D.O., Forest City; Ray F. Miller, Mason City; Patricia Ehrich, Grundy Center; Larry D. Foster, Newton; Larry D. Beaty, State Center; A. Ivan Pakiam, West Des Moines; John M. Grzybowski, Des Moines; Frederick C. Husted, Des Moines; Robert S. Brown, West Des Moines; Stephen C. Gleason, D.O., West Des Moines; Deepak Midha, Creston; A. John Elliott, Des Moines; Marvin M. Hurd, Des Moines; Theodore D. Scurletis, Des Moines; Harlo Hove, Des Moines; Roy E. Brackin, Oskaloosa; and Tony Kunz, Des Moines.

# The New Commitment Law

SELIG M. KORSON, M.D., F.A.P.A.
Independence, Iowa

*The Iowa General Assembly has enacted a new law which sets forth procedures to be followed in the commitment of the mentally ill. This summary provides a glimpse at several main aspects of the law prior to implementation January 1, 1976.*

IN RECENT YEARS there has been broad general concern throughout the United States on the involuntary commitment of individuals to mental hospitals. Court action challenging the constitutionality of existing laws in various states caused the Subcommittee on Psychiatric Care of the Iowa Medical Society to appoint a special committee to study the matter and make recommendations. This committee joined forces with a counterpart committee appointed by the Iowa State Bar Association. The opinion reached was (1) the present Iowa commitment law has constitutional flaws, and (2) an entire new approach was needed. After extended study, the joint IMS-ISBA committee, at the request of the Legislative Human Resources Committee, provided the results of its labors to a Legislative Subcommittee on Commitment. The culmination of this was a modified bill which won overwhelming approval in the Iowa General Assembly. The new law will become effective on January 1, 1976.

Although there are portions of the new law which may prove controversial and difficult to implement, it is nevertheless a hallmark attempt to protect the patient's civil rights, while at the same time protecting his right to treatment, even though his judgment is so impaired that he does not seek treatment voluntarily. This is graphically illustrated by the definition of "seriously mentally impaired," which states, "the condition of a person who is afflicted with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to his or her hospitalization or treatment and who (a) Is likely to physically injure himself or herself, or others if allowed to remain at liberty without treatment; or (b) Is likely to inflict serious emotional injury on members of his or her family or others who lack reasonable opportunity to avoid contact with the afflicted person if the afflicted person is allowed to remain at liberty without treatment."

The preceding definition provides for the physical protection of the patient and those about him. In this regard it considers the rights of the family members to involve the mentally ill member in the custody and treatment process rather than to allow the family structure to disintegrate. In all aspects, maximum emphasis in the law is placed on preserving the patient's right to liberty.

## JUDICIAL EMPHASIS

The new commitment law, in essence, abolishes county hospitalization commissions, and makes the task of deciding whether to commit patients to mental hospitals more of a judicial procedure. The law provides that "the hearing in the district court shall be conducted in as informal a manner as may be consistent with orderly procedure and all persons not necessary for the conduct of the proceedings shall be excluded, except persons having a legitimate interest in the proceedings." This stipulation will allow privacy and avoid the aspects of a public trial. The person under consideration will have a right to be present, and to cross-examine witnesses. Those individuals lacking funds will not be deprived of their rights but may call expert witnesses and may be represented by counsel at public expense. The District Court may commit a person to a mental hospital upon

This summary has been prepared at the request of the Subcommittee on Psychiatric Care of the Iowa Medical Society, of which Dr. Korson is a member. Dr. Korson is superintendent of the Mental Health Institute in Independence and is also assistant clinical professor of psychiatry at The University of Iowa College of Medicine.

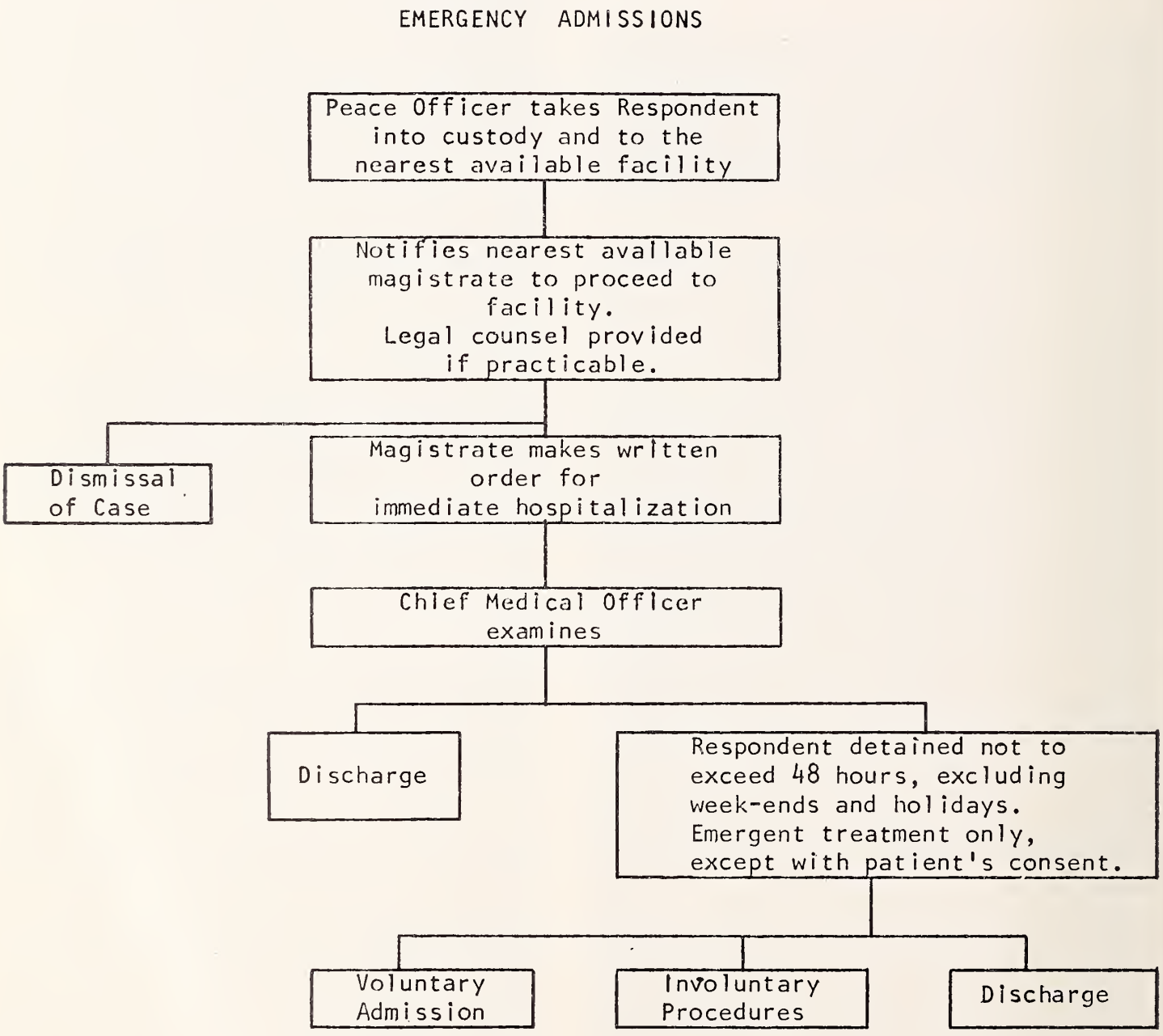
finding by clear and convincing evidence that he or she is "seriously mentally impaired."

Evaluation of the individual is made by the hospital psychiatric staff and a report must be submitted to the Court in a specified period of time. Based on the psychiatric evaluation, disposition of the case is made by ordering either (a) immediate discharge of the patient, or (b) continued hospitalization with periodic report to the Court, or (c) treatment on an outpatient basis, or (d) treatment elsewhere.

The new law provides an emergency commitment procedure which contains judicial safeguards. This provision mandates immediate hospitalization in cases where persons presumed to be mentally ill are likely to "injure themselves or others if not immediately detained."

## CHARTS

The several charts which accompany this summary afford a glimpse at the procedures which must be followed with respect to involuntary admissions, voluntary admissions and emergency admissions.



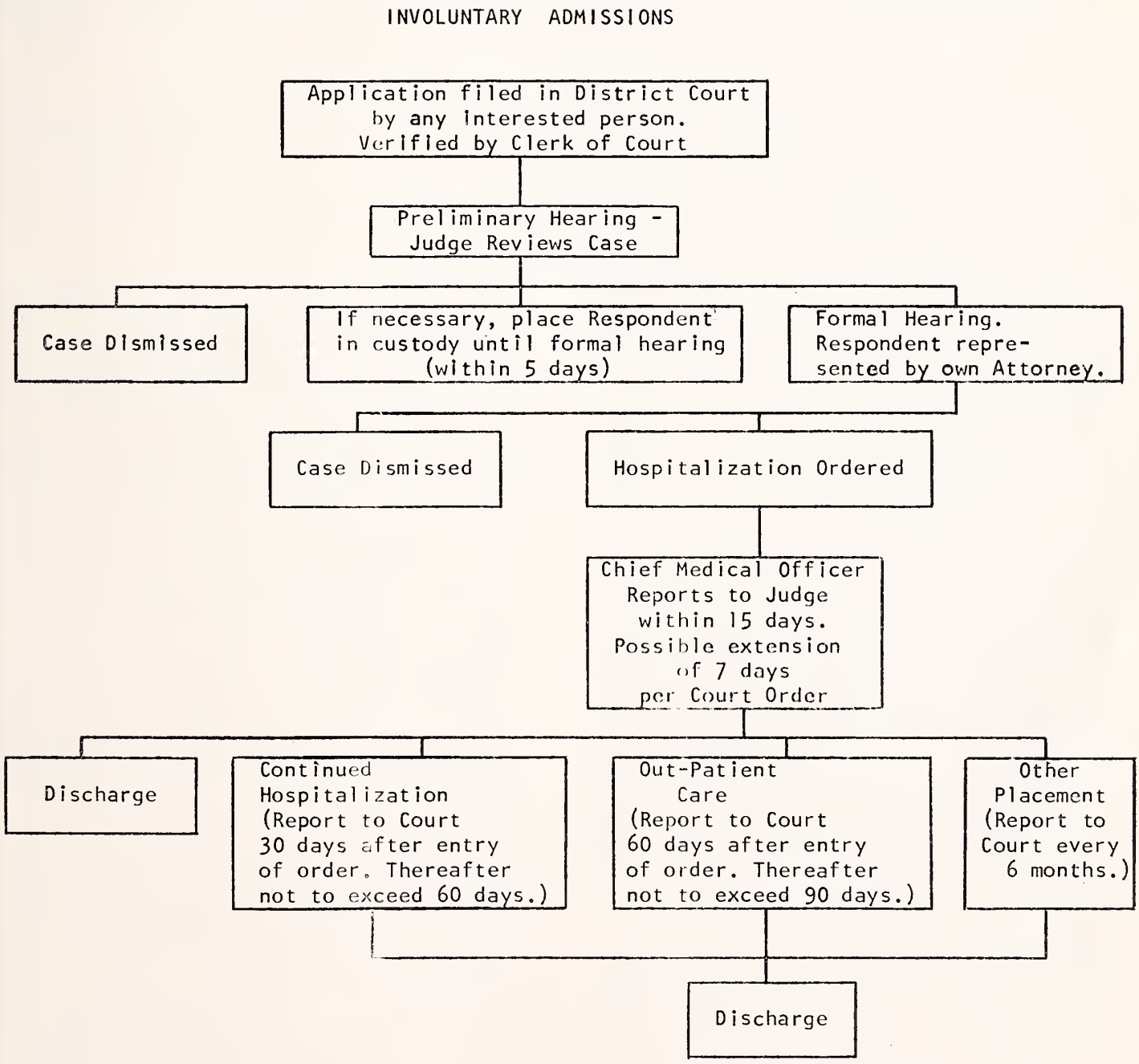
## PATIENT ADVOCATE

The new law further authorizes the appointment of an "advocate" by the District Court in each county "to represent the interests of all patients involuntarily hospitalized by that Court in any matter relating to the patient's hospitalization." The specific qualifications of an "advocate" are not spelled out in a definitive way.

Another section of the new law protects the confidentiality of the involuntary hospitalization proceedings.

The law provides not only for the protection of the patient's constitutional rights but his "legal, medical, religious, social, political, personal and working rights and privileges which he would enjoy if he were not hospitalized, so far as is possible, consistent with effective treatment of that person and of other patients in the hospital."

The new law introduces to Iowa the concept of Court-ordered treatment on an out-patient basis. This is intended to permit needed after-care, hopefully to obviate the necessity of re-hospitalization. The Court-mandated outpatient treatment may

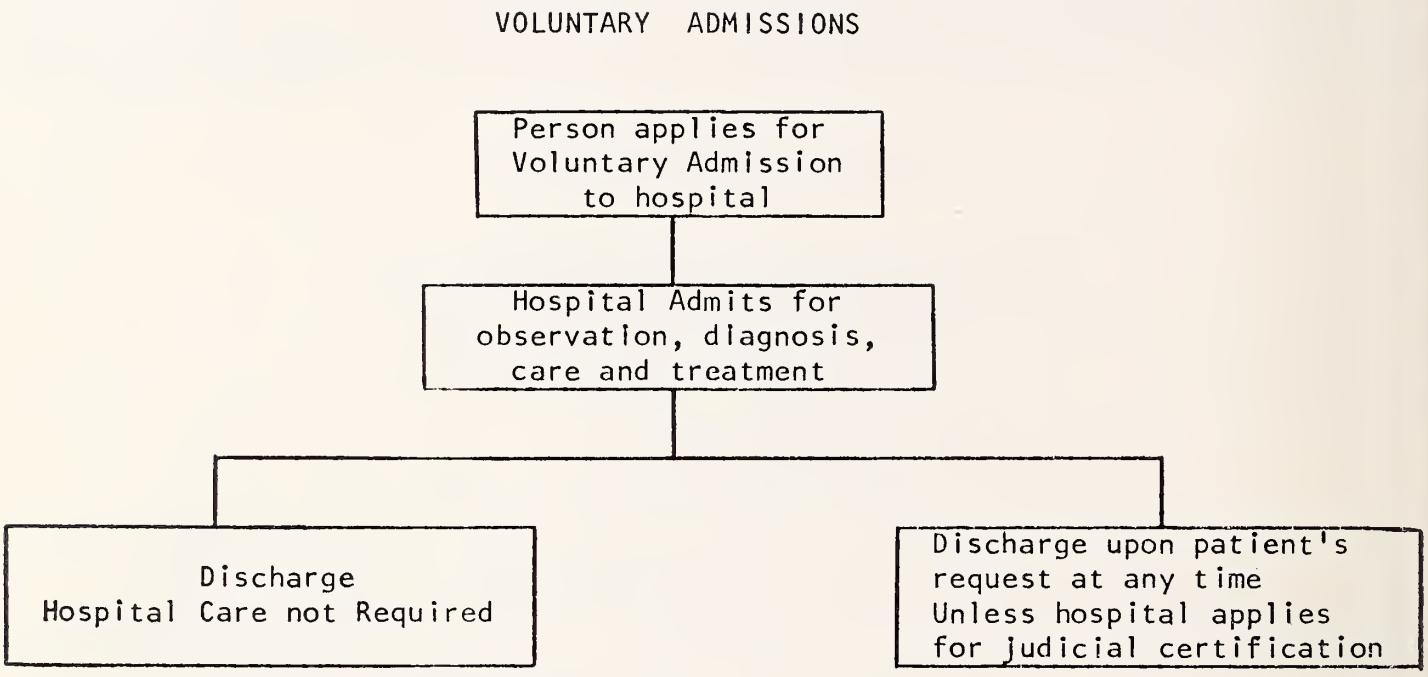


raise serious question as to the efficacy of psychotherapy under such procedures.

Provision is also made for appointment of special judicial officers to handle hospitalization cases in counties where district judges may not be sufficiently accessible to handle these matters expeditiously.

A further stipulation in the law makes certain that legal incompetency is not equated with commitment per se, but must be dealt with in a separate adjudication.

The new law contains numerous amendments to bring present statutes into harmony with its main thrust—the protection of the patient's civil rights and, just as importantly, with the individual's right to treatment.




## MEDICAL MISCELLANY

*(Continued from page 453)*

**COMPETENCY . . .** Subject of peer review/quality assurance/physician discipline is covered in an IMS paper reviewed in September by the Board of Trustees. Approval was given to general content of the paper with further study and recommendations requested by the Board.

**ALCOHOLISM . . .** IMS co-sponsorship of five regional conferences on alcoholism was authorized by the Board of Trustees. Basic planning for the series is being done by the Powell III Alcohol Unit of Iowa Methodist Medical Center.

**EMERGENCY SERVICES SEMINAR . . .** Authority was given by the IMS Board in September to cooperative participation with the AMA in the presentation of a Seminar on Emergency Medical Services. Funding is anticipated by the Ciba-Geigy Pharmaceutical Company. Early planning is in process.

**PROFESSIONAL LIABILITY . . .** Interim Study Committee of Iowa General Assembly met October 20 and 21 and has a 2-day session set in November. IMS was requested to provide information on malpractice screening panels, information on activities of the Board of Medical Examiners, plus certain economic data on physicians.

**USUAL PROFILES . . .** Blue Shield provided to Iowa physicians in October a listing of their usual fees as they appear in the BS records. Purpose of the project is to allow for physician verification and updating of those fees which are incorrect or out of date.

**PHYSICIAN/PHARMACY CODE . . .** IMS Executive Council approved October 21 a revised version of Physician/Pharmacist Code of Understanding which has been under joint study for a period of time. Distribution of the new code to IMS members is anticipated.

**REAFFIRMED . . .** On recommendation of the IMS Committee on Medical Services, the Executive Council reaffirmed on October 21 guidelines on the surgical treatment of obesity which were first approved in 1974.

SCIENTIFIC ARTICLES

# High Pressure Injection Injuries to the Hand

WILLIAM F. DeCESARE, M.D., and
B. L. SPRAGUE, M. D.
Iowa City

*Extensive surgical debridement is the treatment of choice for high pressure injection injuries of the hand. Six case reports are presented to underscore the need for rapid and adequate surgical debridement.*

TECHNICAL ADVANTAGES in farming and industry have increased incidence of high pressure injection injuries to the hand. In industry many compounds are applied by airless spray guns which create pressures of 3500 psi (pounds per square inch).[3, 4, 5] Machinery and parts are painted routinely by such apparatus. Similarly commercial grease guns are capable of producing devastating hand injuries.[6] Finally, on the farm, where hydraulic systems provide more efficient methods of farming, the possibility of a high pressure injection of hydraulic fluid is possible from a hose connection or leak.

The airless paint spray gun, grease gun or faulty hydraulic hose presents a similar threat to hand injury. These devices produce or work under pressures ranging from 2000 to 3500 psi. When the material in these types of systems is inadvertently released close to the hand a small puncture wound results. The material is rapidly injected and quickly spreads by pressure dissection of tissue planes. The volar spaces in the hand are virtually closed compartments and tolerate poorly any sudden distension caused by materials introduced under high pressure. Local ischemia, edema, and tissue necrosis result from the increased pressure. Secondly, the material injected is locally toxic to tissues. Hydrocarbons in petroleum products may cause perineural inflammation and damage. A chemical inflammatory response is common and may lead to further tissue destruction. The possibility of secondary bacterial infection is enhanced by these pathological events.

In the past 6 years we have treated 6 patients with high pressure injection injuries. Five were injured while using airless paint spray guns. One patient had his first web space injected with hydraulic fluid from a press. Despite reports[4, 5, 6] of high pressure injection injuries in the literature, there is limited understanding among physicians as to the significance of a high pressure injection injury. These cases illustrate the need for immediate and extensive surgical debridement even though there is an innocuous appearing puncture wound at the site of injection. We present the following cases to help primary treating physicians become more aware of these common injuries.

The authors are associated with the Department of Orthopedics at the University of Iowa College of Medicine.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF NOVEMBER, 1975.

Figure 1. Swollen first web space, right hand 24 hours after injection.

## CASE REPORTS

1. A 15-year-old male was injured when a high pressure airless spray gun (3000 psi) released 19% lead silicate paint into the volar aspect of his right hand. He was treated initially by debridement of the skin edges around the entrance wound and oral antibiotics. The patient was seen at University of Iowa Hospitals 24 hours after the injury with severe pain and increased swelling. Physical examination revealed a small entrance wound at the proximal flexion crease over the second metacarpal. The hand was markedly swollen on the volar and dorsal surface (Figure 1). Neurovascular exam was normal. His white blood count was 16,200 with a marked left shift. X-rays revealed the lead paint visible in the soft tissues. Under general anesthesia, extensive inflammation and paint were found in the thenar space and the muscle belly of the first dorsal interosseous. No inflammation was found proximal to the volar carpal ligament, which was released. After debridement, the wound was packed open. High doses of intravenous antibiotics were given (initial culture grew alpha-hemolytic streptococci). Five days later a second general anesthetic was given and the wound was again debrided and secondarily closed over a twist drain. The wound subsequently healed well and the patient had no functional impairment.

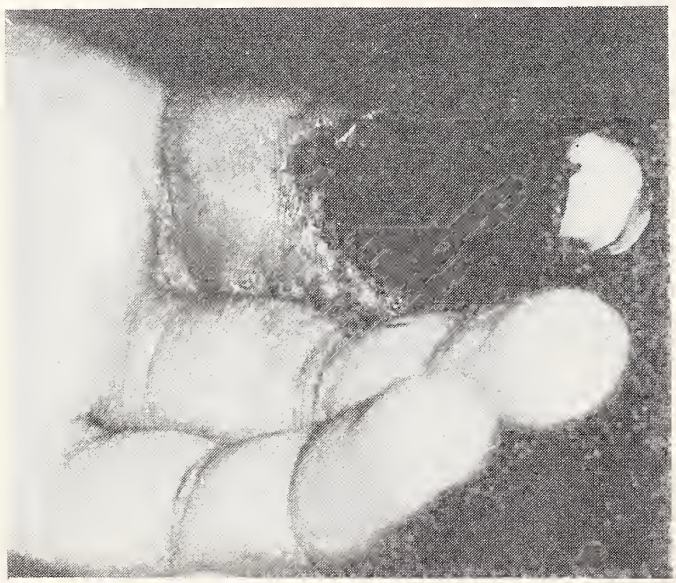


Figure 2. Gangrene of left index finger one week after injection.

2. A 24-year-old male was struck on the tip of the left index finger by a jet of paint when attempting to clean the nozzle of a high pressure paint gun. Initial treatment consisted of tetanus toxoid and analgesics. One day later he was hospitalized with severe pain and swelling of the finger and treated with intravenous antibiotics, hot packs and "local drainage." The patient was referred to the University of Iowa Hospitals six days after the injury because of blackening of the finger tip (Figure 2). Physical examination revealed necrosis to the PIP joint and marked inflammation with tenderness volarly. The white blood count was 9,800. A PIP amputation and palmar debridement was performed and the wound was packed open. Pseudomonas Aeruginosa was cultured and the patient was given intravenous Gentamycin. At a second debridement four days later, further necrosis necessitated revision of the amputation to the MP joint level and the palmar wound was closed over a drain.

3. A 31-year-old male was seen at University of Iowa Hospitals 3 hours after injection of paint by a high power spray gun into the right hand and the distal palmar crease over the flexor tendon sheath to the ring finger. Surgical debridement was recommended, but the patient refused treatment and left the emergency room against medical advice. He returned 5 days later because of severe pain and swelling (Figure 3). Physical examination revealed marked swelling of the hand with tenderness to palpation over the mid palmar space and the volar compartment of the forearm 4 inches proximal to the volar carpal ligament. Neurovascular exam was normal. His white blood count was 15,600.

Under general anesthesia, the mid palmar space and distal forearm (with release of the

volar carpal ligament) were debrided of necrotic, purulent tissue (Figure 4). The neurovascular bundles were carefully dissected from the surrounding inflammatory tissue. The wound was packed open and 4 days later the patient was taken back to the operating room where a second debridement and secondary closure of the wound over a drain was performed (Figure 5). The patient left the hospital without consent two days later and we have been unable to contact him for follow up examination.

4. A 30-year-old male was injured at the DIP crease on the volar surface of the index finger by a jet of paint from a power spray gun. He was hospitalized elsewhere and treated with oral antibiotics, intramuscular corticosteroids but without surgical debridement. He was seen at University of Iowa Hospitals 7 days after the injury with the finger white and ischemic from the PIP joint distally and lack of sensation on the volar surface from the mid portion of the middle phalanx distally. All inflammation was limited to the finger. His white blood count was 11,400. Debridement on the day of admission revealed extensive necrosis surrounding the aluminum paint embedded in the soft tissue and pulp of the finger. Paint was found within the neurovascular bundles but not in the flexor tendon sheath. A PIP amputation was necessary at a second debridement 4 days later.

5. A 37-year-old male suffered a paint gun injury to the volar surface at the level of the MP joint of the left long finger with the injection of "mineral spirits" (nozzle velocity of 3000 psi). He was treated as an inpatient 24 hours later with antibiotics and analgesics, but no debridement. He was transferred to University of Iowa Hospitals 7 days later because of increased pain and swelling in the hand and forearm. Exam on admission revealed necrosis of the long finger to the level of the MP joint, swelling of the hand and forearm and inability to move his fingers because of pain. Both volar and dorsal compartments of the forearm were decompressed, the long finger was amputated at the MP joint level, necrosis and the volar surface of the palm and wrist were debrided. He required multiple skin grafts subsequent to this for closure of wounds. Function of the hand is poor because of contractures of the flexor tendons.

6. A 29-year-old male suffered injection of hydraulic fluid from a press into his left thumb-

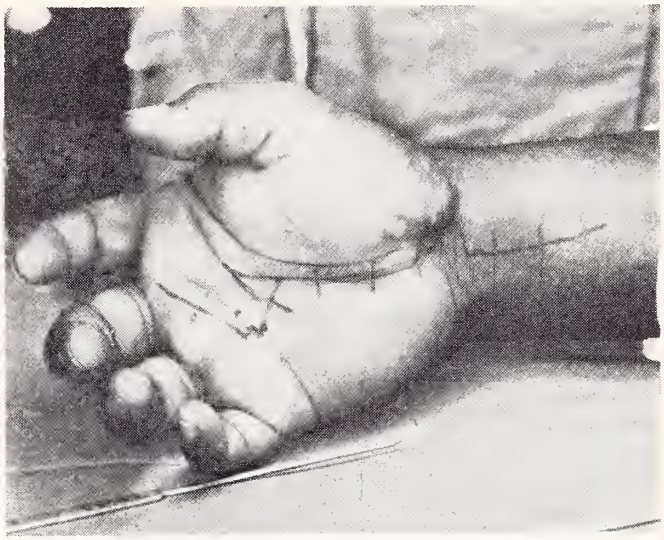


Figure 3. Right hand 5 days after high pressure injection injury with operative approach illustrated.

Figure 4. Purulent material and necrotic tissue released during decompression.

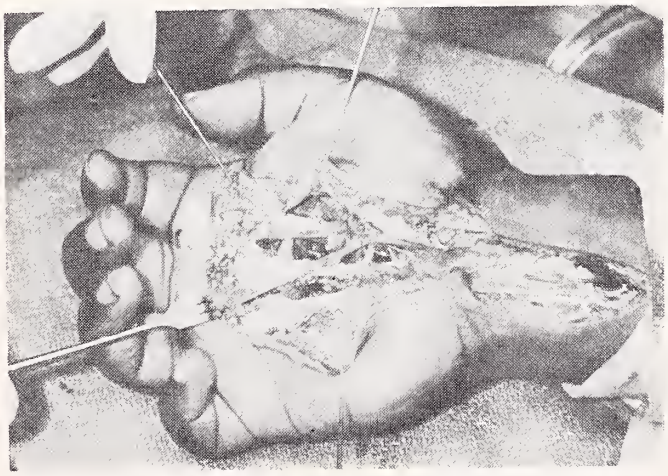


Figure 5. Palm of hand following extensive debridement.

index web space. Initial treatment consisted of local debridement and primary wound closure. Three weeks after injury, the area of injection became swollen, tender, and began to drain purulent material. Drainage persisted and the patient was seen 3 months later at University Hospitals. Incision and drainage and debridement of the thumb-index web space were performed. The pathological report revealed granulomatous inflammation and cultures subsequently grew mycobacterium fortiutum. The wound healed secondarily and required skin grafting.

## DISCUSSION

The standard paint spray-gun operates by mixing compressed air with paint prior to its release through a nozzle. These guns could reach pressures of 25 to 50 pounds per square inch (psi). Approximately 15 years ago an airless paint gun was introduced which forces nonatomized paint through the gun by an electrically operated hydraulic pump. Small, hand held units of this type create pressures of 80 to 100 psi, but the large commercial paint guns can operate at pressures in excess of 3500 psi.

Painters accustomed to using the older air-spray guns frequently wipe the nozzle with a finger or hold the fingertip against the nozzle while releasing the trigger, thereby allowing the compressed air to back up and clean the hoses. With the high pressure airless guns, this maneuver causes direct injection of paint into the finger because of the hundredfold increase in pressure.

Workman, in 1963, first described this injury in a patient using a paint gun at 80 psi pressure.[7] Prior to 1967, 5 cases had been described, all involving the index finger and all resulting in amputation.[1, 3, 7] In 1967, Start *et al* presented 14 cases and emphasized the necessity of extensive surgical debridement.[5] They also warned against the use of digital block anesthesia believing this increased vasospasm and soft tissue swelling. They found amputation was not required in any case in which debridement was performed within 10 hours after injury (except one case that had received a digital block.)

With these high pressure injections there is a certain amount of local tissue damage at the point of entry. However, the paint or grease can be forced along tissue planes on tendon sheaths and is frequently found well proximal to the point of injection. This foreign material acts as a chemical irritant resulting in intense inflammation and swelling. This leads to vessel thrombosis, ischemia and necrosis with secondary bacterial infection.

## CONCLUSION

Local debridement at the point of entry is completely inadequate. We wish to reinforce the importance of immediate extensive surgical debridement of all devitalized tissue and foreign material with careful preservation of neurovascular and musculotendonous structures. These wounds should be packed open and a second surgical debridement should be performed 3 to 4 days later. If the wound is clean at that time, secondary closure may be done. High doses of intravenous antibiotics should be given and the extremity should be immobilized and elevated throughout this treatment period. The success of this method of treatment is directly proportional to the expedience of adequate surgical debridement and decompression.

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# OPHTHALMIA PROPHYLACTIC

The following state regulation took effect October 27, 1975:

470—2.1 (140) *Treatment of Infant Eyes.* The Iowa State Department of Health approves only a one percent solution of silver nitrate from single-dose unopened wax ampules in each conjunctival sac as an ophthalmia prophylactic for newborn infants' eyes. Silver nitrate, once applied, should not be followed by a normal saline flush.

# Drug-Induced Anemia Associated With Glucose-6-Phosphate Dehydrogenase Deficiency

FRED MEISTER, Pharm.D.,
LEE ENDSLEY, M.D., and
JOSEPH D. SCHMIDT, M.D.
Iowa City

*A drug-induced hemolytic anemia associated with hereditary G-6-PD deficiency is reported in a 69-year-old Black male. A brief review of the literature is presented. Since G-6-PD deficency is the most common defect of erythrocyte metabolism and its primary clinical consequence is drug-induced hemolytic anemia, its importance should be stressed in the diagnosis and subsequent treatment of patients in population groups with a high incidence of this heterogeneous trait.*

THE SINGLE MOST common defect of erythrocyte metabolism is glucose-6-phosphate dehydrogenase (G-6-PD) deficiency. The consequence of clinical concern with this hereditary disorder is increased susceptibility to hemolytic anemia. Hemolytic episodes can be induced by several drugs used frequently in clinical practice although other stressful stimuli may precipitate hemolysis in the enzyme-deficient patient. A recent experience with a patient having previously unrecognized G-6-PD deficiency serves as an example of this problem.

## CASE REPORT

E. W., a 69-year-old Black male, visited his local physician complaining of decreased urinary stream, slight hesitancy with prolonged urination, nocturia and postvoiding dribbling for the past few years. He was admitted to his local hospital on December 18, 1973 with a history of 2-3 days of fever, chills and burning on urination. He also complained of two recent blackout spells associated with chills but lasting only a few seconds. Laboratory data at this time revealed an anemia with a hemoglobin of 10.8 grams%, hematocrit of 33% and RBC count of $3.58 \times 10^6/cm^3$ and a leukocytosis of 15,800 with a marked shift to the left. His urine was alkaline with numerous pus cells and bacteria. His serum chemistries were normal with the exception of a blood urea nitrogen (BUN) of 49 mg% and mild elevations in creatinine phosphokinase (CPK) and serum glutamic oxaloacetic transaminase (SGOT). Treatment was begun using phenoxymethyl penicillin K (Pen-Vee-K®) 250 mg t.i.d., sulfisoxazole plus phenazopyridine (Azo Gantrisin®) 2 tablets q.i.d. and ferrous sulfate spansules 150 mg b.i.d. His dysuria, fever and chills promptly cleared. During the course of his hospitalization an intravenous pyelogram was performed which was normal with the exception of bony lesions suggestive of either Paget's disease or osteoblastic metastases. Serum acid phosphatase activity was at the upper limits of normal.

The patient was transferred to the University of Iowa Hospitals on January 2, 1974 with the diagnosis of possible metastatic prostatic carcinoma. On admission all medications were discontinued. The patient had no known allergies and had never been treated for anemia. Physical examination was normal but for a prostate gland that was 1+ enlarged, smooth, slightly boggy, nontender and benign in consistency. Laboratory data revealed a hemoglobin of 9.4 grams%, hema-

Dr. Meister is associated with the Section of Clinical Pharmacy, College of Pharmacy, and Drs. Endsley and Schmidt are associated with the Department of Urology, University of Iowa Hospitals and Clinics.

tocrit of 30% and RBC count of 3.2 × $10^6$/$cm^3$. His white cell count was normal at 6,100 with a normal differential. Serum chemistries including repeat BUN and acid phosphatase were normal. The x-ray changes noted in his pubis and ischium were interpreted as Paget's disease. Radio-nuclide bone scan showed increased uptake in the above areas with findings compatible with both Paget's disease and metastatic prostatic carcinoma. Evaluation of his normochromic normocytic anemia was pursued. Three stool specimens were negative for occult blood. An upper gastrointestinal series, barium enema and sickle cell tests were negative. Both direct and indirect Coombs tests were negative. However, a G-6-PD concentration was found to be decreased to 1.17 IU (normal range 2.12-2.64 IU), and his anemia was therefore related to this deficiency. On January 10, 1974 he underwent panendoscopy with the finding of a small bulbous urethral stricture and nonobstructive prostatic enlargement. Transperineal needle biopsy of the prostate gland showed no evidence of malignancy. Prior to discharge on January 15, 1974 his hematologic parameters showed improvement with a hemoglobin of 11.4 grams%, hematocrit 39% and RBC count of 4.2 × $10^6$ cc. Discharge diagnoses included 1) glucose-6-phosphate dehydrogenase deficiency, 2) Paget's disease and 3) bulbous urethral stricture. Follow-up to date reveals the patient to be doing well without evidence of recurrent anemia.

## DISCUSSION

The prevalence of G-6-PD deficiency among various racial and ethnic groups is noted to be of substantial clinical significance (Table 1). Deficiency of G-6-PD is a heterogeneous trait of intermediate dominance which is genetically linked to the X-chromosome.[1] In population groups where this defect occurs, males are affected most commonly.[2] In this country 3.5-7.3% of randomly selected patients have been reported to be deficient in G-6-PD activity; however, 13% of American Negro males exhibit this trait.[3, 4] The enzyme deficiency of the Negro variant (A-) is primarily due to an increased rate of enzyme degradation rather than a decreased rate of production. The result is therefore a loss of enzyme molecules from the erythrocyte as it ages. Caucasian G-6-PD deficient variants, in contrast, are characterized both by a decrease in the number and most notably, in the specific activity of the enzyme molecules.[5] Clinically the difference between the

***IMPORTANT INFORMATION:*** *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

*Indications:* Lomotil is effective as adjunctive therapy in the management of diarrhea.

*Contraindications:* In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

*Warnings:* Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

*Usage in pregnancy:* Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

*Precautions:* Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

*Adverse reactions:* Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

*Dosage and administration:* ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

*Overdosage:* Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

*Dosage forms:* Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Negro variant and the Caucasian variants is the degree of hemolytic susceptibility of their erythrocytes when exposed to stressful stimuli. The Negro variant is a self-limited hemolytic potential since the level of G-6-PD in young erythrocytes, though not quite normal, is distinctly higher than in older cells. Caucasian variants do not have this self-limiting hemolytic potential since they have low levels of G-6-PD throughout their entire erythrocyte population and their existing G-6-PD has a decreased intrinsic ability to perform its specific biochemical function.[4, 7] As a result, affected Caucasian subjects may respond to a drug such as sulfisoxazole (Gantanol®) with a severe, even fatal, hemolytic anemia.

As illustrated by this patient, the majority of persons who are G-6-PD deficient have no apparent clinical manifestations until they are exposed to certain drugs (Table 2) or other stressful stimuli. An obvious drug-induced hemolytic anemia may be difficult to interpret, however, since the disease being treated may in itself be responsible at least in part for the hemolytic process. Factors known to induce or enhance the hemolytic anemia associated with G-6-PD deficiency other than drugs include viral and bacterial infections, hypoglycemia, the level of G-6-PD activity, hyperthermia, and metabolic disturbances such as acidosis.[1, 3, 7, 8]

TABLE 1

INCIDENCE OF GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY*

| *Group* | *Incidence* |
|---|---|
| Sephardic Jews (males) | |
| Kurds | 53 |
| Iraq | 24 |
| Persia | 15 |
| Cochin | 10 |
| Yemen | 5 |
| North Africa | 1-4 |
| Arabs | 4 |
| Iranians | 8 |
| Sardinians (males) | 4-30 |
| Greeks | 0.7-3 |
| Negroes | |
| American | 13 |
| Nigerians | 10 |
| Bantu | 20 |
| Leopoldville | 18-23 |
| Bashi | 14 |
| Pygmies | 4 |
| Watutsi | 1-2 |
| Asiatics | |
| Chinese | 2 |
| Filipinos | 13 |
| Indians—Parsees | 16 |
| Japanese | 3 |
| Micronesians | 0-1 |
| American Indians | |
| Oyana (males) | 16 |
| Carib (males) | 2 |

* Modified from: Marks, P. A. and Banks, J.: "Drug-induced hemolytic anemias associated with glucose-6-phosphate dehydrogenase deficiency: a genetically heterogeneous trait." Ann. N.Y. Acad. Sci. 123:198 (1965).

TABLE 2

COMMONLY USED DRUGS REPORTED TO PRODUCE HEMOLYSIS IN G-6-PD DEFICIENT PATIENTS—IMPLICATED ALONE OR IN ASSOCIATION WITH COMPLICATING FACTORS[2, 7, 8]

| |
|---|
| Aminosalicylic acid (PASA) |
| Acetylsalicylic acid (ASA) |
| Ascorbic acid (Vitamin C) |
| Chloroquine |
| Menadione, water soluble Vitamin $K_3$ |
| Methylene blue |
| Nitrofurantoin (Furadantin, Marcrodantin®) |
| Phenacetin |
| Primaquine |
| Probenecid (Benemid®) |
| Salicylazosulfapyridine (Azulfidine®) |
| Sulfisoxazole (Gantrisin®) |
| Sulfamethoxazole (Gantanol®) |
| Sulfamethoxypyridazine (Midicel®) |
| Sulfone (Dapsone®) |

The clinical course of drug-induced hemolytic anemia in G-6-PD deficient Negro males has been well characterized.[1, 3, 4, 7] For descriptive purposes, Dern *et al*[9] have arbitrarily divided the hemolytic episode into three phases. The acute hemolytic phase presents clinically on the second or third day of drug administration or stressful stimulus and persists with increasing severity during the next 5-7 days.[8, 14] The hemolytic episode of the patient described was most likely precipitated by his acute cystitis, manifesting initially as a mild anemia. By treating the patient's disease with sulfisoxazole plus phenazopyridine, the degree of hemolytic anemia was correspondingly enhanced. It has been established that sulfonamides can induce hemolysis in patients with G-6-PD deficiency as well as in patients with normal levels of this enzyme.[10, 11, 12] It should also be noted that phenazopyridine has been implicated as a cause of hemolytic anemia and may therefore be a contributing factor.[13]

The degree of hemolysis which occurs during the acute phase is not only dependent on the nature of the drug and its dosage but also on the

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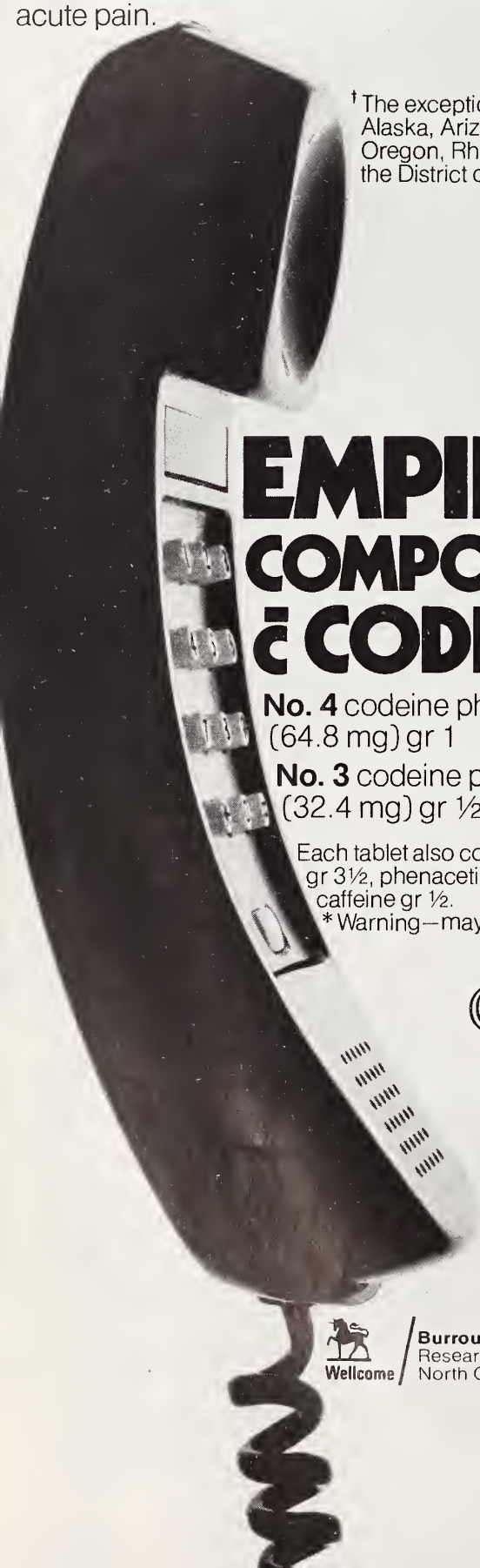

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level of G-6-PD activity.[8] This patient had a G-6-PD titer of 1.17 IU, a deficiency of approximately 50% of normal. The degree of his clinical hemolysis and subsequent response is therefore better correlated and evaluated as being primarily a drug-induced anemia associated with G-6-PD deficiency. With the exception of this enzyme deficiency found during the hematological workup, all the tests including the sickle cell tests were negative. It is of interest to note that the frequency of G-6-PD deficiency has recently been shown to be slightly higher in patients with sickle cell disease than in the general American Negro population.[6]

The recovery phase begins 7-10 days after initiation of drug therapy and may require up to 40 days for hematologic recovery to take place. Reticulocytosis develops initially followed by a rise in the hemoglobin and hematocrit until normal values for the patient are reached.[8, 14] We are unable to document a reticulocytosis in this patient due to the time lapse between initial hospitalization and his transfer to University Hospitals. However, significant improvement in his hematologic status is readily apparent for the period of time during the patient's second hospitalization.

The equilibrium or resistant phase begins when the hematologic status returns to normal. The anemia resolves, and no abnormal hemolysis persists during this phase even though the drug or other stressful stimuli continue to challenge the erythrocytes. This phenomenon pertains only to those variants having a self-limiting hemolytic potential such as found in American Negro males.[8, 14] Since this patient was adequately treated for his primary medical problem and his hematologic status was satisfactorily resolved, he was discharged prior to reaching his equilibrium phase.

No satisfactory treatment has thus far been devised for G-6-PD deficiency. If a drug-induced hemolysis occurs in an affected patient, the offending drug(s) should be withdrawn. If the drug in question is critical to the patient's welfare, administration may be continued in the A-type of deficiency.[1] In other variants, however, discontinuation of the drug is indicated with the concomitant transfusion of packed red blood cells.[12]

## REFERENCES

The references noted in this article may be obtained from either the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## THANKSGIVING

*"If you want a good time, give something away."*

Somewhere I came across this little quotation. At this time it has deep meaning. We cannot receive if we do not give. The tradition of Thanksgiving Day, unique to us Americans, gives us an opportunity to reflect upon life, our blessings, and also upon our liabilities. The ledger-page of life has credits and debits as any other form of balance sheet; and these must be taken into account as we look upon ourselves in retrospect. Our prayers of Thanksgiving may include our health, our good fortunes, and possession of worldly goods. Yet, we must also include the intangible assets which have been given to us in a more subtle manner.

First, let us give thanks for the progress of our profession which enables us to give more and better service to our patients. The advances in medical knowledge enable our patients to live longer, happier lives. New drugs, new instruments, and new skills allow procedures and successes that were only dreams of former years. Yet, we cannot rest upon our successes in a smug, complacent manner. What we have received must be given with compassion in the truest traditions of our honored profession. Provision of these wonderful things to our patients requires full understanding of all the implications of our professional acts. We must not become mercenary and exceedingly impressed by very simple things just because they are new. Illogical thought processes often place an unreasonable monetary value upon a simple procedure merely because it may be unique. Reality may dictate otherwise. Reflect upon that.

Next, our thanks must go out for the station in life we have obtained through our profession. Some of us have come from very humble beginnings, and by virtue of professional successes and monetary gains, we have increased our social station. We speak of the "good old days," but in reality would we want to relive the hardships of past years? We cry about the oil shortages, the cost of living, the lack of craftsmanship of the goods we buy, and the decaying mode of life we lead. But, is it really that horrible? Is life so unbearable? Our mode of practice is far advanced over driving a horse-drawn carriage through a snowstorm during the darkness of night to minister to a child dying of pneumonia. No antibiotics were available. Our hospitals provide every known convenience for our comfort as well as for the patients. Our offices are comfortable with many conveniences to assist us. Our automobiles provide us with comfortable transportation from home to hospital to office and on house calls. Our homes are among the better ones in our city. Truly for all these blessings we must be thankful.

We are concerned that our society is decaying more and more with each passing day; that crime will eventually destroy us, and another fall of civilization will ensue. Is it really that bad? People have been killing each other since Cain slew Abel; people have been stealing since Adam lifted that apple from a tree in the Garden of Eden. We worry about our government being corrupt and blemished by Watergate irresponsibilities. Such actions cannot be condoned, but our systems of life have mechanisms to deal with such problems and we progress in a good life style. For all that we must be very thankful.

Our thanks must go out also for family and friends. How terrible loneliness must be. We have our families in close proximity via modern marvels of communication though thousands of miles may separate us in reality. To have close family ties can be an asset beyond measure—a spouse taken for better or for worse, through sickness and in health; our children, as well as our parents and siblings. Friends and companions add more to that store of treasure. Our friends give us much and to them we must return favor, for not to give decreases the opportunity to receive and friendship declines.

Our storehouse is exceedingly full when we count among our assets an accurate accounting of all these things for which we must be thankful. We have pride in our profession, a realization of how well we live, the benefits of our society, and the blessings of family and friends. Thanksgiving Day is only another day on the calendar. We should be thankful every day.—M.E.A.

## ETHICS OF FETAL RESEARCH

The American Academy of Pediatrics has proposed a Code of Ethics in connection with the research use of fetuses and fetal material. This is a wise step. It will give an added ethical and legal basis to research in an area which has been shadowed by controversy. When a fetus is viable after delivery, the ethical obligation is to sustain life so far as possible. A viable fetus is one having the ability to survive independently and maintain heart-beat and respiration. It is recognized in some instances the techniques used to aid a distressed fetus may be so new that in some degree the act may be considered experimental. To this end, the Code directs that before any human experimentation committee approves research, they should be satisfied that the research is valid, that the information cannot be obtained in any other way, and that the researchers have the necessary facilities, skill and integrity.

The Code also states that tests may be carried out on the fetus in utero providing they are intended to benefit the mother and/or her expected child, and if informed consent has been obtained. No monetary exchange should be made for fetuses or fetal material. Full records should be kept by the institution where the research is being conducted, and local and state laws governing autopsy must be obeyed. Inasmuch as the question of whether the fetus is viable has such major ethical importance, the determination of viability must be made by a physician other than the investigator wishing to use the fetal tissue in research.

The Academy's Code reiterates that research on the fetus and newborn is of the greatest importance in contributing to the health and welfare of the entire population. Such research, motivated by humane concern, should be fostered and continued, subject to adequate clearly defined safeguards. The efforts by the Academy of Pediatrics to this end are to be applauded.—M.E.A.

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# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## THE OTHER SIDE OF THE COIN

If you have read many of these little commentaries of mine, you may have concluded that I see continuing education in a positive light. That is, I call it fun, professionally stimulating to physicians, beneficial (ultimately) to patients, the potion that keeps us young, refreshed and renewed, and other similar up-beat images.

But in all fairness, I should point out a different aspect. Continuing education can be related to requirements and standard-setting which may be perceived as (or truly be) harassing or threatening; it can be used censorially or even punitively. Today's social climate tends to be somewhat paranoid, formal and repressive as it deals with issues of professional authority, responsibility and accountability, even while it has grown permissive and informal about mores of dress, speech and sex. This stern ambience around our professional life imposes rules of many types, and those rules and formalistic procedures have entered the arena of Continuing Medical Education. Setting standards on performance and results (not only on certifying and credentialing), assuring quality, providing remediation of education, and disciplining those who are consciously or unconsciously going astray, are indeed elements present in today's CME world. And most assuredly, these elements feel negative, or at least less than purely noble and uplifting—less than noble unless one acknowledges the great value of rules and procedures in achieving a higher good to which we subscribe.

Do we recognize and accept the idea that fear of pain and other dread consequences are necessary to human development along with reward and attainment of pleasure? Put more visually, is some stick appropriate and necessary along with some carrot? What remains, then, is to decide the appropriate mix.

Personally, I feel concern for setting and maintaining high standards, for continual monitoring of the process of care, and for dispensing discipline in the occasional instances needed. But I continue to be counted among those who would prefer to stress the upbeat characteristics of Continuing Medical Education. When the carrot is made sufficiently tasty, then a *very* small amount of supplemental stick should suffice.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

# Continuing Education Courses & Conferences

*Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.*

| | |
|---|---|
| Nov. 3-7 | Intensive Course in Pediatric Nutrition |
| Nov. 6-8 | Iowa Clinical Surgical Society |
| Nov. 7 | What's New in Stroke |
| Nov. 7-8 | Reunion for Class of 1950 |
| Nov. 13-15 | International Symposium on Cataract Operations and Their Sequelae |
| Dec. 1-4 | Cardiology Today |
| Dec. 3 | Ophthalmology Clinical Conference |
| Dec. 4 | Conference on Blood Gases and Blood Gas Analysis |
| Dec. 5 | Cardiac and Respiratory Disease Conference |
| Dec. 10-11 | Conference on Obstetrics and Gynecology |

# State Department of Health

## HUMAN HYPERIMMUNE RABIES GLOBULIN NOW AVAILABLE AS "DRUG OF CHOICE"

Originally licensed on July 12, 1974, and available for commercial distribution in very limited supply early in September of 1974, Rabies Immune Globulin (Human) provides a welcome alternative to the previously mandatory risk of horse serum reactions in the treatment of persons exposed to rabies. Because of short supply, its use was originally limited to persons known to be hypersensitive to antirabies serum of equine origin on the basis of past history and/or positive skin tests, or who were pregnant. Recently, Cutter Laboratories announced that the supply of their human rabies immune globulin (HYPERAB) was adequate for general, rather than limited, use. As a result, Rabies Immune Globulin (Human), hereafter referred to as "HRIG," should now be used in preference to equine hyperimmune rabies serum, in standard post-exposure rabies prophylaxis treatment.

HRIG is available to physicians in Iowa through the Division of Disease Prevention of the State Department of Health, and the pharmacy of the University of Iowa Hospitals at Iowa City. Calls to the State Department of Health during office hours should be directed to 515-281-5424, 5643, 5605, or 5606, and to 515-281-5559 at other times. Calls to the University of Iowa pharmacy should be directed to 319-356-2577.

Under currently recommended rabies post-exposure treatment guidelines, use of antiserum, as well as vaccine, is indicated if there is a reasonable possibility that rabies virus has been introduced into a previously unimmunized person. When indicated, HRIG should be used regardless of the interval between the original exposure and the initiation of treatment, and should be given at the time of the first vaccine dose in a single administration of 20 international units (IU) per kilogram body weight. Up to half of the recommended dose should be used to infiltrate around the site of the wound and the rest administered intramuscularly. Equine antirabies serum, the only previously available mode of serum therapy, was associated with significant allergic reactions in up to 40% of recipients.[1]

Though considered adequate to meet expected demand, HRIG is a relatively scarce biological product with a high cost. It is packaged in vials of 2 ml and 10 ml size containing 150 international units of rabies antibody per ml. The cost of HRIG is $17 per ml or $170 for the "average" 75 kilogram adult. This cost is about 400% higher than the $31.50 for a comparable amount of equine antiserum, but it is expected that this increased cost will be offset by eliminating the morbidity associated with allergic reactions from the equine serum. The standard course of 23 doses of Duck Embryo vaccine recommended for use in conjunction with rabies antiserum in post-exposure treatment adds an additional $63 to the cost of post-exposure rabies treatment, independent of the size of the patient.

Although Iowa has not had a case of human rabies since 1951, rabies is endemic among certain wildlife and domestic animal species within the state. Human exposure to proven or potentially rabid wild or domestic animals results in a significant number of persons being subjected to post-exposure rabies prophylaxis every year in Iowa. According to surveillance conducted by the Division of Disease Prevention of the State Department of Health, through its rabies exposure consultation service,[2] it is known that at least

70 persons undergo rabies prophylactic treatment annually. It is likely that the number of actual treatments in the State is higher than this since not all are reported to the Department through this service.


REFERENCES

1. Corey & Hattwick: Treatment of persons exposed to rabies, JAMA 232:272-6, 1975.
2. State Department of Health: Rabies in Iowa Animals, Journal of the Iowa Medical Society, May 1973.


# Morbidity Report for September, 1975

| Disease | Sept. 1975 | 1975 to Date | 1974 to Date | Most September Cases Reported From These Counties |
|---|---|---|---|---|
| Adenovirus | 1 | 5 | | Linn |
| Amebiasis | 4 | 17 | 28 | Boone, Franklin, Linn, Washington |
| Ascariasis | 7 | 15 | 10 | Franklin, Hardin, Linn |
| Chickenpox | 69 | 6711 | 6279 | Dallas, Dubuque, Floyd, Linn, Ringgold |
| Combined infestations | 2 | 11 | | Franklin |
| Conjunctivitis | 72 | 958 | 590 | Clinton, Johnson, Marion, Muscatine |
| Encephalitis | | | | |
| California virus | 1 | 1 | 1 | Clinton |
| ECHO 4 | 1 | 3 | | Buchanan |
| CEV virus | 1 | 1 | | Webster |
| SLE virus | 5 | 5 | | Johnson, Linn, Louisa, Polk |
| WEE virus | 2 | 2 | | Woodbury |
| Erythema infectiosum | 3 | 141 | 537 | Floyd, Jackson, Linn |
| Gastrointestinal viral inf. | 1361 | 16145 | 6864 | Bremer, Chickasaw, Davis, Madison |
| Giardiasis | 8 | 20 | 38 | Franklin, Jasper, Johnson, Polk |
| Hand, Foot & Mouth assoc. with Coxsackie A16 | 1 | 1 | | Polk |
| Hepatitis, A (Infectious) | 20 | 128 | 213 | Fayette, Linn |
| Hepatitis, B (Serum) | 7 | 75 | 69 | Scattered |
| Hepatitis, type unspecified | 1 | 25 | 30 | Scott |
| Impetigo | 141 | 509 | 306 | Benton, Chickasaw, Linn, Winnebago |
| Infectious Mononucleosis | 78 | 892 | 723 | Black Hawk, Johnson, Linn |
| Influenza-like illness | 1767 | 37989 | 91875 | Bremer, Linn, Madison, Story, Worth |
| Meningitis | | | | |
| Aseptic | 3 | 8 | 52 | Fayette, Polk, Warren |
| Bacterial | 1 | 9 | 5 | Jasper |
| ECHO 4 | 1 | 2 | 12 | Winneshiek |
| ECHO 21 | 1 | 1 | | Polk |
| *H. influenza* | 1 | 13 | 4 | Muscatine |
| Staph | 1 | 1 | | Polk |
| Type unspecified | 4 | 30 | 31 | Hamilton, Lee, Scott |
| Meningoencephalitis assoc. with ECHO 21 | 2 | 2 | | Linn |
| Mumps | 64 | 1065 | 1670 | Linn, Marshall, Polk, Wapello |
| Pasteurellosis | 3 | 4 | | Cerro Gordo, Dubuque, Scott |
| Pediculosis | 43 | 258 | 330 | Black Hawk, Des Moines, Winnebago |
| Pertussis | 1 | 3 | 13 | Muscatine |
| Pinworms | 1 | 35 | 52 | Clay |
| Pneumonia | 77 | 839 | 711 | Buena Vista, Scott, Story |
| Rabies in Animals | 4 | 84 | 106 | Delaware, Greene, Humboldt, Jasper |
| Rheumatic fever | 1 | 11 | 47 | Scott |
| Ringworm, body | 36 | 207 | 136 | Black Hawk, Fayette, Hancock, Linn |
| Ringworm, scalp | 2 | 9 | 9 | Story, Winneshiek |
| Rocky Mountain Spotted Fever | 1 | 5 | | Page |
| Salmonellosis | 16 | 151 | 156 | Scattered |
| Scabies | 33 | 316 | 71 | Benton, Dubuque, Johnson |
| Shigellosis | 4 | 55 | 233 | Dallas, Polk, Pottawattamie, Scott |
| Streptococcal infections | 392 | 7325 | 7668 | Dubuque, Johnson, Madison, Polk |
| Trichuriasis | 6 | 9 | 3 | Hardin, Linn |
| Tuberculosis, total ill | 16 | 94 | | Scott, Woodbury |
| Tuberculosis, bact. positive | 14 | 59 | | Scott, Woodbury |
| Venereal Diseases | | | | |
| Gonorrhea | 725 | 5161 | 4650 | Black Hawk, Linn, Polk, Scott |
| Syphilis | 27 | 227 | 309 | Black Hawk, Hancock, Pocahontas, Scott |
| Chancroid | 1 | 1 | | Polk |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | |
|---|---|---|---|
| Coxsackie B3 | 2 | Eaton's agent | 4 |
| Cytomegalovirus | 1 | Herpes simplex | 14 |
| ECHO 4 | 1 | Herpes zoster | 2 |

# Medical Assistants

by TENORA MEYER, CMA

## 52 NEW CMA's IN IOWA

A total of 1,338 CMA certificates will be awarded this year. This is the highest number in history and more than double last year's record. Of these 1,338, 52 are Iowans. Of these successful candidates, 1,300 will receive certificates for the first time, the remainder earning certification in an additional category.

This is the first year the new basic Certification Examination has been offered, and many candidates chose to sit for this test of general medical assisting expertise, with 750 candidates receiving certificates in this category. Specialty category certification was awarded to 588 candidates, with the following certificates earned: 170 Administrative; 349 Clinical; 23 Pediatric; 41 Administrative/Clinical; 2 Clinical/Pediatric; and 3 Administrative/Clinical/Pediatric.

Beginning in 1976, the certification examinations will be offered twice yearly. Each fall the basic Certification Examination will be given in the convention city just prior to the AAMA annual meeting. Then annually on the first Friday in June the basic Certification Examination plus all three specialty examinations will be administered at approved test centers throughout the country. There are more than 95 test centers in the country. Information may be obtained from the Certifying Board, American Association of Medical Assistants, One East Wacker Drive, Chicago, Illinois 60601.

The Iowans newly certified are:

Marcia Ann Alff, Avoca—CMA-C, Velma L. Anderson, Winterset—CMA, Nancy Brown Austin, Des Moines—CMA-C, Janet Barnes, Ankeny—CMA, Shirley L. Binkerd, Des Moines—CMA-A, June E. Blanford, R.N., Cedar Falls—CMA-C, Patricia Ann Brick, Iowa City—CMA, Jenny Ann Brokaw, Ankeny—CMA, Diana Sue Buck—Des Moines—CMA-A, Katherine L. Chapman, Cedar Rapids—CMA-A, Joan F. Clark, Des Moines—CMA-C, Virginia Ann Cohrs, Council Bluffs—CMA, Sharon Jean Comer, Des Moines—CMA-C, Sandra Jean Dingbaum, Dyersville—CMA, Winnie Donovan, Sioux City—CMA-C, Donna Eye, Palo—CMA-C.

Candace Joy Ferguson, Des Moines—CMA, Margaret E. Finnell, Riverton—CMA, Mary Ellen Hatley, Des Moines—CMA, Martha E. Haverkamp, Remsen—CMA, Jane Mailander, Atlantic—CMA-C, Dianne Kay Menneke, Des Moines—CMA-A, Kathleen D. Moffitt, Ankeny—CMA-C, Mary Ann Neave, Marion—CMA-C, Lynn Kay Neugent, Rolfe—CMA, Diane K. Nissen, Harlan—CMA-C, Donna E. Petrik, Fairfax—CMA, Vickey E. Porter, Fairfield—CMA, Victoria K. Hawkins, Council Bluffs—CMA-A, Carole Y. Hilton, Cedar Rapids—CMA, Tricia Hirsch, Exeter—CMA, Jane M. Hite, Vinton—CMA, Etha M. Humphrey, Polk City—CMA-C, Barbara J. Kasper, Iowa City—CMA, Alberta Jean Kosmach, S. Newton—CMA, Peggy Jo Lane, Cedar Rapids—CMA-C, Doris L. Liggeit, Des Moines—CMA-A.

Pamela Jo McBride, Marion—CMA, Judith Lu Ann Richards, Indianola—CMA, Debra Kay Routh, Des Moines—CMA-C, Maxine L. Rozeboom, Winterset—CMA, Jill Ellen Sands, Manchester—CMA, Kristine L. Schiffer, Cedar Rapids—CMA-C, Catherine Ann Schmitt, Sioux City—CMA-C, Debra Lynn Schumacher, Fayette—CMA, Sheila M. Scribner, Des Moines—CMA-A, Bonnie Sommer, Waterloo—CMA-C, Linda Stratmann, Hampton—CMA, Deborah D. Strayer, Des Moines—CMA-A, Terri Lynn Taft, West Des Moines—CMA, Pauline W. Tappan, R.N., Sioux City—CMA-A, Patsy Louise Wehr, Waterloo—CMA-C.

## LAW AND ETHICS QUIZ (True or False)

——1. A physician is obligated to advise patients against the performance of needless operations.

——2. Informed consent is not required in an emergency situation.

——3. The Law of Agency holds only that a medical assistant is liable for her own actions as an agent of a physician.

——4. A patient who fails to follow a physician's instructions is guilty of contributory negligence and cannot recover damages in court.

*(Please turn to page 479)*

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

**Preparation and distribution of patient drug information**

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

**Realistic problems must be considered**

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

**What information is appropriate?**

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

**Positive aspects of patient drug information**

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

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Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

**Emotionally unstable patients pose a special problem**

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

**Legal implications of the patient package insert**

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

**How do we handle an insert for medication used for a placebo effect?**

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

**Preparation of the package insert**

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

*Pharmaceutical Manufacturers Association*
*1155 Fifteenth Street, N.W.*
*Washington, D.C. 20005*

P·M·A

# About IOWA Physicians

**Dr. Alson E. Braley** will close his medical practice in Iowa City on November 1. . . . **Dr. Bob G. Field** has joined **Drs. Parker K. Hughes, Richard M. Moore** and **Norman K. Rinderknecht** in the practice of obstetrics and gynecology in Des Moines. Dr. Field received the M.D. degree at University of Illinois School of Medicine and completed his internship and residency at University Hospitals in Iowa City. . . . **Dr. Daryll M. Eggers,** Marshalltown, was guest speaker at the monthly meeting of area LPNs at the Fisher Community Center in Marshalltown. . . . **Dr. Donald Berge** has joined **Drs. J. Y. Hendricks, R. L. Borgman** and **S. A. Moeller** in family practice in Clear Lake. Dr. Berge received the M.D. degree at U. of I. College of Medicine and served his residency at Midland Hospital, Midland, Michigan. . . . **Dr. Thomas Graham,** Iowa Falls, has resigned from Health Planning Assembly of Hardin County. . . . **Dr. John Stewart,** longtime Ottumwa radiologist, retired September 1. A graduate of Northwestern University Medical School, Dr. Stewart served his residency in radiology at St. Luke's Hospital and Kansas City General Hospital in Kansas City, Missouri. Dr. and Mrs. Stewart will retire to Cape Coral, Florida.

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**Dr. James H. Coddington,** Humboldt, was installed as president of Iowa Academy of Family Physicians at recent annual meeting in Des Moines. **Dr. Don J. Ottilie,** Oelwein, was named president-elect; **Dr. Keith Garber,** Corydon, vice president; and **Dr. George A. Kern,** Des Moines, secretary-treasurer. **Dr. Larry Boeke,** West Union, and **Dr. Wayne Rouse,** Boone, were named to board of directors. **Dr. V. L. Schlaser,** Des Moines, IMS president, was selected delegate to American Academy of Family Physicians and **Dr. Lee E. Rosebrook,** Ames, alternate. . . . **Dr. Garo Chalian,** Clinton, has been named president of Iowa Urological Society; **Dr. Warren V. Wulfekuhler,** Mason City, vice-president; and **Dr. Curtis Clark,** Ames, secretary-treasurer. . . . **Dr. Fredrick Schultz** will begin the practice of medicine in Rock Rapids next summer. Dr. Schultz received the M.D. degree at U. of I. College of Medicine and will complete his residency in family practice at Johns Hopkins in June 1976. A pediatrician, Dr. Schultz will be sponsored by the National Health Service Corps. . . . **Dr. Truce Ordona,** Davenport, and **Dr. Harry Mahannah,** Bloomfield, were program participants at a seminar on emotional child abuse at Indian Hills Community College in Ottumwa. . . . **Dr. Glenn Blome,** retired Ottumwa surgeon, was guest speaker at meeting of Wapello County Historical Society. Dr. Blome spoke on "A Century of Medicine in Wapello County."

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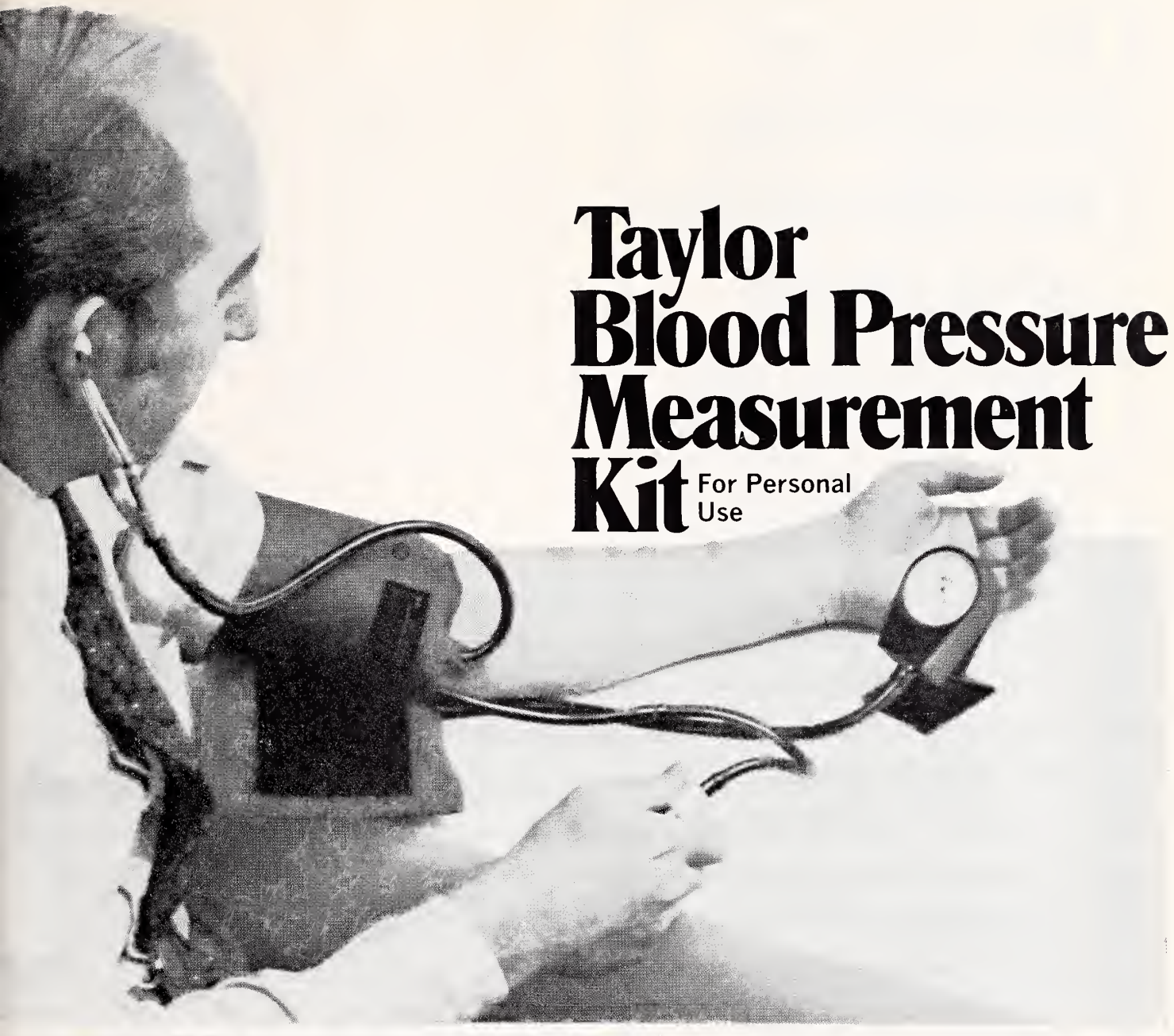
**Dr. T. A. Ericson,** Des Moines, was guest speaker at recent meeting of Dallas County Medical Society and Auxiliary. . . . **Dr. Ivan E. Brown** was honored at a reception for his many years of medical service in Hartley. **Dr. Paul Boone,** who joined Dr. Brown at Hartley Medical Center in September, was also welcomed to the community at the same event. . . . **Dr. John Lanning,** former Charles City physician, has joined the staff of the Rockford Medical Clinic. Dr. Lanning received the M.D. degree at University of Oklahoma School of Medicine and served his residency at University of Minnesota and the Mayo Clinic. He has practiced in Charles City for the past eight years. . . . **Dr. Suendra Kumar** has joined the Medical Associates staff in Clinton. Dr. Kumar received his medical education in India. He interned at Cook County Hospital in Chicago and



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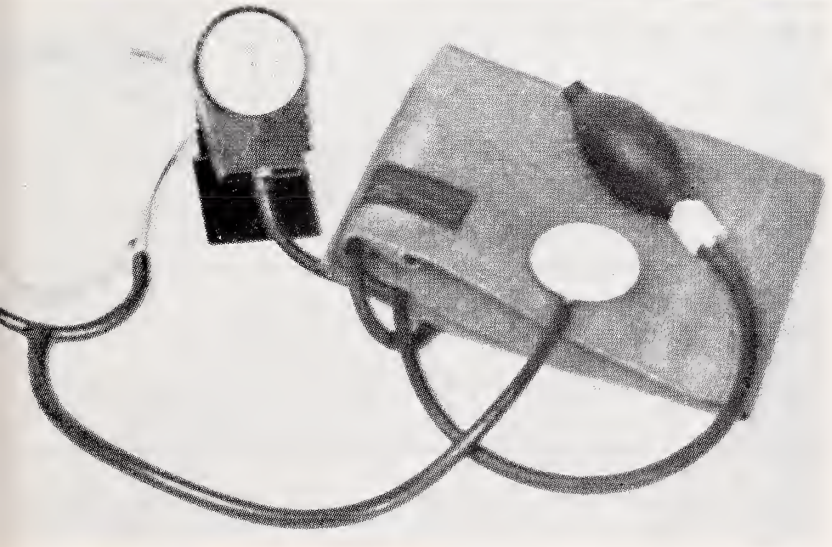

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completed a surgical residency at Veterans Administration Hospital in Hines, Illinois. For the past two years Dr. Kumar has been serving a residency in thoracic and cardiovascular surgery at University of Missouri Medical Center. . . . Four Iowa City physicians, **Drs. Ronald M. Lauer, Richard M. Schieken, Robert T. Soper** and **David P. Synhorst,** participated in annual meeting of American Academy of Pediatrics in Washington, D. C. Dr. Lauer served as moderator for scientific presentations on cardiology; Dr. Schieken discussed rheumatic fever, Dr. Soper spoke on surgical problems in premature infants; and Dr. Synhorst discussed experimental techniques in pediatric cardiology.

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**Dr. William Fischer,** former Iowa City physician, opened a practice of family medicine in Elkader in October. A native of Iowa City, Dr. Fischer attended Harvard and the University of California Medical School at San Francisco. He interned at Wayne County General Hospital, Detroit, Michigan, and was in private practice in Newberry, Michigan, before locating in Iowa City. . . . **Dr. Charles E. Driscoll** and **Dr. Francis L. Pisney** will join **Drs. Harold Bastron** and **Jack Fickel** at Red Oak's Family Care Center next summer. Dr. Driscoll and Dr. Pisney will begin practicing in Red Oak in July, 1976, following completion of service with the Air Force and National Health Service Corps, respectively. Both are 1971 graduates of U. of I. College of Medicine and completed their residency training in family practice at Ball Memorial Hospital in Muncie, Indiana. . . .

## DEATHS

**Dr. Robert B. Allender,** 53, Des Moines obstetrician and gynecologist, died October 5 at Iowa Methodist Medical Center. A native of Boone, Dr. Allender received the M.D. degree at U. of I. College of Medicine and had practiced his specialty in Des Moines for 20 years. Memorials may be made to the Iowa Methodist Building Center.

**Dr. R. C. Gutch,** 87, Chariton physician for 52 years, died September 18 in Knoxville, Tennessee, where he had made his home for the past seven years. Dr. Gutch received the M.D. degree at St. Louis University, St. Louis, Missouri. He was a life member of the Iowa Medical Society.

## MEDICAL ASSISTANTS

*(Continued from page 474)*

——5. A medical assistant can be held liable for honest errors of judgment in the course of administering emergency treatment.

——6. A physician is generally required to report to a local police department all injuries from violence and deaths resulting from violence.

——7. The consent of the husband to an operation on his wife is necessary.

——8. The right to give or withhold an autopsy usually rests with the executor.

——9. The medical acts of most states requires that only a licensed individual be allowed to administer an injection or withdraw blood from a patient's vein.

——10. Consent given to a surgeon has not been construed to include his assistants.

ANSWERS

| | | | | |
|---|---|---|---|---|
| 1. T | 3. F | 5. F | 7. F | 9. T |
| 2. T | 4. T | 6. T | 8. F | 10. F |

ANSWERS

## INDIANOLA SEMINAR

A seminar for medical assistants was held September 28, at the Indianola Country Club, Indianola, Iowa. The morning program was devoted to cardiopulmonary resuscitation instruction. Dr. Donald Bowman, Director of Pre-Retirement Program, Drake University, spoke on "Attitudes Paralysis" in the afternoon. A presentation was made by Robert S. Brown, M.D., Des Moines ophthalmalogist, on "Ocular Emergencies." "The Embattled Cell" was shown following Dr. Brown's presentation, and a review of Anatomy and Physiology was conducted by Delores Benning, R.N., Instructor at Des Moines Area Community College.

Proper CPR instruction is absolutely essential and if properly trained, the medical assistant can assist the doctor more efficiently in performing the necessary treatment.

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## INDEX TO ADVERTISERS


American Medical Association ..... 458B

Burroughs Wellcome ..... 468

Geigy Pharmaceuticals ..... 454A, B

Lilly, Eli, & Company ..... 449

Medical Protective Company ..... 479

Merck, Sharp & Dohme ..... 466B, C, D

Milwaukee Sanitarium Foundation, Inc. ..... 470

Pharmaceutical Manufacturers Association .... 474D, 475

Prouty Company ..... 478

Roche Laboratories ..... 450-451, 474B, C, 483-484

Roerig, J. B., & Company ..... 474A

Searle, G. D., & Company ..... 466, 466A

Smith, Kline and French Laboratories ..... 458A

Younkers ..... 477

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• Summary of H.F. 803—Page 493
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• Physician/Pharmacist Code—Page 502

DECEMBER 1975

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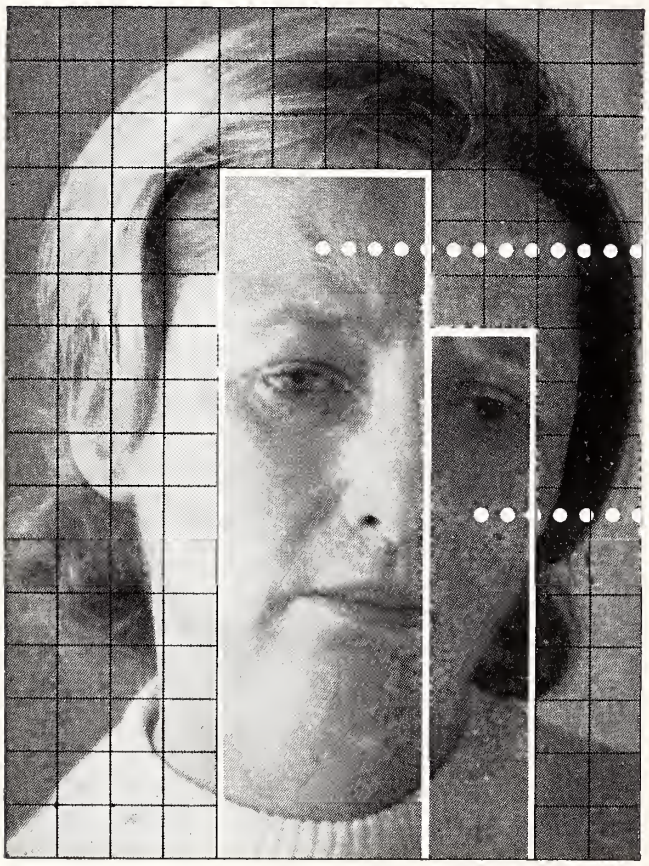

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# respond to one

According to her major
mptoms, she is a psychoneu-
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xiety. But according to the
scription she gives of her
elings, part of the problem
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his is because her problem,
though primarily one of ex-
ssive anxiety, is often accom-
anied by depressive symptom-
ology. Valium (diazepam)
n provide relief for both—as
e excessive anxiety is re-
ved, the depressive symp-
ms associated with it are also
ten relieved.

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ges in using Valium for the
anagement of psychoneu-
tic anxiety with secondary
epressive symptoms: the
ychotherapeutic effect of
alium is pronounced and
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anxiety states
with associated
depressive symptoms

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on to habituation and dependence. In
egnancy, lactation or women of child-
earing age, weigh potential benefit
gainst possible hazard.

**recautions:** If combined with other psy-
notropics or anticonvulsants, consider
arefully pharmacology of agents em-
oyed; drugs such as phenothiazines,
arcotics, barbiturates, MAO inhibitors
nd other antidepressants may potentiate
s action. Usual precautions indicated in
atients severely depressed, or with latent
epression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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# President's Page

The year 1975 is nearing its end. Each and every one of us should take time to reflect a bit on the past 12 months. There have been heartaches, disappointments, accomplishments, pleasures and happiness.

The IMS has had its share of crises, accomplishments and progress. The principal crisis is that of liability insurance coverage for Iowa physicians. The problems of availability and cost continue to weigh heavily upon us. We collectively rolled up our sleeves and spent many manhours encouraging enactment of H.F. 803. This is a stepping stone to a permanent solution. Incidentally, a summary of H.F. 803 appears in this issue.

I wish to thank each and every member, the Staff, the Auxiliary and even those who are not members (we need you in our ranks in 1976) for their efforts in keeping the stone of medical progress rolling forward.

Start the new year with your happy foot forward, your hand extended in friendship and a determination to make 1976 a better year. By doing so, you can be assured your circle of friends will increase.

SEASONS GREETINGS—HAPPY HOLIDAYS, and may God give you guidance in the coming year.

Sincerely,

V. L. Schlaser MD

*V. L. Schlaser, President*

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# IOWA Medical Miscellany

**PROFESSIONAL LIABILITY . . .** Further steps to improve Iowa's professional liability situation have been approved by the IMS Executive Council. New legislative recommendations include (a) an Iowa Code change to allow for prospective arbitration; (b) a requirement that plaintiffs provide a 60- or 90-day notice of their intent to sue; (c) a mechanism to pay certain high awards or settlements on an ongoing basis rather than a lump sum; (d) an expert witness stipulation wherein such individuals would be from Iowa or a contiguous state and represent the specialty area under review; (e) a $100,000 ceiling on awards for non-economic losses; and (f) a specified limit on the level of private liability insurance required of a physician with awards or settlements in excess of the established level to be funded by a separate mechanism. Further proposals call for strengthening Board of Medical Examiners through additional funding, broadened arrangements for the receipt of reports and the conduct of investigations, and responsibility for continuing medical education tied in with licensure renewal. In same vein, recommendation is made that insurers furnish pertinent claims information to the BME via the Insurance Department. Loss prevention activity by the IMS and the Iowa Hospital Association has also been urged.

**ARBITRATION EXPERIMENT . . .** The Iowa Hospital Association and the IMS are developing a proposed arbitration project to permit patients admitted to participating hospitals to choose between the traditional judicial process and arbitration in the event of a dispute. Hope is approximately 25% of the state's hospital beds may be included in any such pilot project; participation by 80 to 90% of the medical staff members will be needed. Iowa arbitration statutes must be altered before the project can be implemented; change must authorize arbitration agreements on a prospective basis. Discussions of this project with key state legislators included a special briefing on November 24.

**INTERIM STUDY COMMITTEE . . .** The 10-member Legislative Committe on Medical Malpractice is continuing its deliberations with meetings on December 9 and 10. While it has requested legislative drafts in several areas, there is no clear indication of the amount of impetus the Committee will give to the subject when the General Assembly convenes next month.

**LEGISLATIVE ITEMS . . .** In addition to further medical liability activity, the Society will involve itself legislatively in 1976 to achieve (a) adequate funding of the family practice residency program, (b) reasonable radiation control, (c) identification of organ donors, (d) formalization of a CME program tied to license renewal, and (e) certificate-of-need statutes to comply with federal requirements.

**FOUNDATION REVIEW . . .** Peer review cases submitted to the Iowa Foundation for Medical Care totalled 769 between January and September; 839 have been resolved in this period; the difference involves carry over cases from 1974.

**LCM SEMINAR . . .** A January 7 Seminar for IMS Legislative Contact Men at Society Headquarters will include a review of professional liability developments with emphasis on anticipated Society efforts in this area.

**DUES STATEMENTS . . .** 1976 IMS dues statements were mailed in mid-November to Iowa physicians. A prompt response is encouraged.

*(Please turn to page 504)*

THE JOURNAL OF THE IOWA MEDICAL SOCIETY

VOL. 65 No. 12
DECEMBER 1975

## TABLE OF CONTENTS

Iowa Medical Liability Legislation—A Summary of House File 803
James B. West, J.D. . . . . 493

Blue Cross-Blue Shield Now Under One Roof 498

Physician-Pharmacist Code of Understanding . . . . . 502

### EDITORIALS

Christmas Music . . . . . 505

Aid for Hospital Libraries . . . . . 506

### SPECIAL DEPARTMENTS

President's Page . . . . . 488

Iowa Medical Miscellany . . . . . 489

Question Box . . . . . 491

Educationally Speaking . . . . . 507

State Department of Health
Health Problems of Vietnamese Refugee Children . . . . . 508

Medical Assistants . . . . . 511

About Iowa Physicians . . . . . 513

In the Public Interest
In Pursuit of Good Physician/Hospital Relations . . . . . 514

### MISCELLANEOUS

Surgical Treatment of Obesity . . . . 497

IMS BC/BS Program Open . . . . . 503

Continuing Education Courses and Conferences . . . . . 506

Index to Volume LXV . . . . . 517

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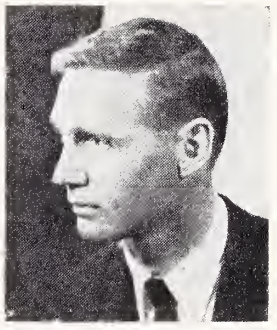
# The Question Box



by ROBERT E. RAKEL, M.D.

## FAMILY PRACTICE STATUS

*Family practice training in Iowa has made significant progress in the past five years. Robert E. Rakel, M.D., professor and head of the Department of Family Practice at the University of Iowa College of Medicine, provides a brief status report with his following responses.*

**What are the current statistics pertaining to family practice training in Iowa at this time? Number of students, residents, training sites, etc.**

There are currently 686 students in the College of Medicine. Over half of these have participated in the MECO program at the end of the freshman year involving 10 weeks of work in a community hospital. In the junior year, 70% of the class selected a family physician as preceptor for two weeks. We presently offer 14 electives during the senior year and over half of the class has taken one or more of these. This year there are 104 residents studying in six residency programs with a seventh in Sioux City opening next year.

**Is the blend between Iowa City-based training and that occurring in other communities seeming to work effectively?**

Our undergraduate programs, under the leadership of Dr. Harold Moessner, are being expanded. Each year more students participate in programs at many locations throughout the state; not only with the Family Practice Residency Programs, but also in smaller communities, through the Medical Education Community Organization (MECO) and preceptorship programs. Our affiliated Family Practice Residency Program Network offers a diversity of program design which is attracting students from around the country, since we can offer them either a University program, a county hospital program or a variety of community hospital programs.

**Are you satisfied with the progress made in the five years you have been in Iowa?**

I feel we have an excellent program with outstanding faculty and high quality residents who are a credit to the University and the State. There is still a great deal yet to be accomplished, however. I am proud of our Statewide Network of Affiliated Residency Programs which will soon be producing an adequate number of family physicians to satisfy the needs of our State. The network is already recognized throughout the country as one of quality. Programs included are:

| *Program* | *Director* | *Residents* |
|---|---|---|
| Broadlawns Polk County Hospital<br>Des Moines, Iowa | Loran F. Parker, M.D. | 26 |
| St. Luke's-Mercy Hospital<br>Davenport, Iowa | Forrest Smith, M.D. | 7 |
| St. Joseph-Mercy Hospital<br>Mason City, Iowa | Richard Munns, M.D. | 3 |
| Iowa Lutheran Hospital<br>Des Moines, Iowa | L. E. Masters, M.D. | 13 |
| St. Luke's Hospital<br>St. Joseph Hospital<br>St. Vincent Hospital<br>Sioux City, Iowa | Gerald McGowan, M.D. | 0 |
| University of Iowa Hospital & Clinics<br>Iowa City, Iowa | Robert E. Rakel, M.D. | 30 |

Although not affiliated with the University, Cedar Rapids has an excellent program contain-

*(Please turn to page 501)*

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# Iowa Medical Liability Legislation— A Summary of House File 803

JAMES B. WEST, J.D.
Des Moines

*Six tort reform measures are contained in the Iowa medical liability legislation of 1975. These several new provisions in the law are summarized here with reference made to the manner in which they are applicable to the Iowa physician.*

IN THE SPRING of 1975 the Iowa General Assembly approved legislation concerned with medical liability. This legislation was identified as House File 803. It was signed into law on June 30, 1975.

One dimension of House File 803 is represented by the creation of a Joint Underwriting Association (JUA). This JUA requires the participation of all liability insurers doing business in Iowa. Its purpose is to write malpractice insurance for health care providers in the event such insurance is not available through the voluntary market. The JUA has been organized in accordance with provisions in the law but it has not been put into operation. Its activation is to occur upon a finding by the Insurance Commissioner that medical malpractice insurance "is not available at a reasonable price." The legislation provides a two-year life for the JUA.

The Joint Underwriting Association is to be self supporting. This means although it would provide insurance to those who cannot otherwise obtain it (and who meet underwriting standards) it will not be inexpensive.

### TORT MEASURES

The more important provisions of House File 803 are the six tort reform measures. Even so, these reforms were not represented as a solution to the medical liability crisis in Iowa. At the most it was hoped they would stabilize the situation and encourage the private insurance carriers to remain in the Iowa market. Efforts must be continued to find additional ways and means of resolving both the real and potential problems. Such efforts are being undertaken by a Special Interim Study Committee on Medical Liability of the Iowa General Assembly. A similar special committee of the Iowa Medical Society is functioning with membership drawn from the Medico-Legal Committee, the Legislative Committee and the Board of Trustees.

The six tort reforms in House File 803 do make significant changes in Iowa law. Iowa physicians should be familiar with these new provisions.

## I. PEER REVIEW IMMUNITY

Section 15 of H.F. 803 adds a new section as follows:

*"A person shall not be civilly liable as a result of acts, omissions, or decisions made in connection with the person's service on a peer review committee. However, such immunity from civil liability shall not apply if an act, omission or decision is made with malice."*

This addition is made to Chapter 147 of the Iowa Code, the chapter which deals with the health related professions.

Section 14 of H.F. 803 adds a definition of peer review: the *"evaluation of professional services rendered by a person licensed to practice a profession."* *"Profession"* refers to those licensed under Chapter 147 of the Code.

Section 14 also defines *"peer review committee"* as *"one or more persons acting in a peer review capacity who also serve as an officer, director, trustee, agent, or member of any of the following:*

Mr. West is the legislative counsel for the Iowa Medical Society.

*"a. A state or local professional society of a profession for which there is peer review.*

*"b. Any organization approved to conduct peer review by a society as designated in paragraph a of this subsection.*

"c. *The medical staff of any licensed hospital.*

*"d. An examining board."*

The statute protects anyone who serves on a peer review committee from liability for such service, unless he acts with malice. In other words, a physician will not be liable for his decisions as to either the physician whose work he is reviewing (protection from a libel and slander suit) or to anyone else (a patient, for example, claiming malpractice by a physician whose work has been evaluated by a peer review committee and found acceptable, and claiming further the members of the peer review committee were negligent in not taking steps to correct or stop the physician's practice), except in the case of malice.

The peer review committee must be acting on behalf of:

1. The state or local medical society (not a specialty society).

2. An organization (for example, a specialty society) approved by the state or local medical society to conduct peer review. (It would seem prudent that such approval be in writing with a copy forwarded to the State Board of Medical Examiners).

3. The medical staff of a licensed hospital, or

4. The medical examining board.

Otherwise, persons serving on a peer review committee are not protected.

In addition the legislature enacted into law House File 816 which provides that directors, officers, and members of voluntary nonprofit corporations shall not be personally liable for any claim based upon an act or omission performed in the reasonable discharge of their lawful corporate duties.

It is suggested that peer review committees be established under the auspices of the Iowa Medical Society or a local medical society (or a specialty society approved for peer review as suggested earlier), or a hospital, which is incorporated as a nonprofit corporation. In this way the physician member should have double protection.

The Iowa Code (Sections 135.40-135.42) has provided that any person or organization can provide any information or data to the Iowa Medical Society or its allied medical societies *"to be used in the course of any study for the purpose of reducing morbidity or mortality,"* and no liability may be imposed for giving such information. This does cover some peer review functions, but not all.

## 2. COLLATERAL SOURCE RULE

Section 16 of H.F. 803 in effect vitiated the "Collateral Source Rule" in medical malpractice cases.

The Iowa courts have followed the "Collateral Source Rule" which provides that benefits received by an injured plaintiff from any source independent of the defendant will not reduce the damages recoverable by the plaintiff from the defendant. In other words, even though an injured plaintiff has been reimbursed for all medical expenses and loss of wages from some other source he can still collect these as damages from a defendant who negligently caused his injuries. *He can be paid twice* under the "Collateral Source Rule." [Rigby v. Eastman, 217 N.W.2d 604 (1974)] The "Collateral Source Rule" prevented any testimony from being presented to the jury indicating the plaintiff received compensation for his losses from another source.

H.F. 803 reversed this rule. The statute now provides that in medical malpractice cases:

*". . . the damages awarded shall not include actual economic losses incurred or to be incurred in the future by the claimant by reason of the personal injury, including but not limited to, the cost of reasonable and necessary medical care, rehabilitation services, and custodial care, and the loss of services and loss of earned income, to the extent that those losses are replaced or are indemnified by insurance, or by governmental, employment, or service benefit programs or from any other source except the assets of the claimant or of the members of the claimant's immediate family."*

This will not be to the disadvantage of any plaintiff—he has already been paid (or will be paid in the future)—but it will prevent the plaintiff from receiving a double payment. Although the statute leaves to the courts the responsibility for establishing appropriate rules to implement the new law, the most probable procedure is that evidence will be introduced showing all of the other (collateral) sources which have paid or will pay the plaintiff's losses and the jury will be

instructed that any damages awarded shall exclude such reimbursed, or to be reimbursed, expenses and losses.

## 3. WRITTEN INFORMED CONSENT

Section 17 of House File 803 provides an optional procedure for a physician to use to meet the requirements of "Informed Consent."

The legal doctrine of "Informed Consent" has been evolving in the courts for 60 years. It was based originally on battery—that any treatment or procedure undertaken without informing the patient of its inherent risks is a battery. The Iowa court has adopted the modern view that the theory of battery should be limited in its applicability to surgery to which the patient has not consented and that there must be a substantial difference between the surgery consented to and the surgery done. Thus, in Iowa, lack of "Informed Consent" is a matter of negligence. Expert testimony is required as to the disclosures required by the physician's medical community. [Perin v. Hayne, 210 N.W.2d 609 (1973)].

The Iowa court has adopted the rule that a physician has a duty to make a reasonable disclosure to his patient of the nature and probable consequences of a suggested or recommended treatment, and to make a reasonable disclosure of the dangers within his knowledge which are incident or possible in such treatment. But the physician does not have to describe in detail all of the possible consequences of such treatment where it might so alarm a patient as to be bad medical practice. To what extent disclosure should be made is a matter of the standard of the physician's medical community. [Grosjean v. Spencer, 140 N.W.2d 139 (1966)].

The question as to whether the duty of disclosure has been met (Informed Consent) is for the jury to determine in the usual case.

Section 17 of H.F. 803 provides a method, which may be used at the option of the physician, by which a legal presumption can be created that informed consent was given. The patient's consent must be in writing and:

1. Set forth in general terms the *nature and general purpose* of the procedure, together with the *known risks,* if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure, with the probability of each such risk *if reasonably determinable;*

2. Carry patient acknowledgment that the disclosure of this information has been made and that all questions asked about the procedure have been answered in a satisfactory manner, and

3. Be signed by the patient or someone who has the legal authority to sign for him if he lacks capacity.

For the presumption to be created the consent must comply in all respects. If it does not comply the common law will be applicable.

The written procedure requires disclosure of the known risks and the probability of each such risk if reasonably determinable. This is not relieved by the standard of the physician's medical community.

The question frequently arises as to what should be done in an emergency when it is difficult or impossible for a physician to fully advise the patient, make full disclosure and obtain the patient's consent. The best practice is to do so if possible. If it is not, a physician should fully adsive and make full disclosure to a person who can legally consent for the patient and obtain such person's consent for the patient. In an emergency which endangers the life or health of the patient (where the patient's consent cannot be obtained) the Iowa court has held it is the duty of the physician to do that which the occasion demands (treatment or surgery) within the usual and customary practice among physicians in the same or similar localities, without the consent of the patient. [Jackovich v. Jocom, 237 N.W. 444 (1931)]. Again, in the usual case this will be a question for the jury.

Unfortunately, there is no legal standard as when the probability of a risk is so slight that disclosure of it need not be made. In the *Perin* case, supra, the probability of the risk of the misadventure which occurred was stated to be two or three-tenths of one per cent. The court did not decide whether the probability of such a risk need be disclosed or not but the court did state that recovery on the basis of failure to advise a patient of the risk would be precluded unless a plaintiff also established he would not have submitted to the procedure if he had been advised of the risk. The written informed consent alternative will not be effective unless the probability of the risk is stated.

It is not anticipated that the written procedure will be used in all cases. It should be used in dif-

ficult, extensive or high risk procedures to give added protection to the physician. Whether it is used or not a physician should always (with the exception of the emergency situation discussed earlier), for his own protection, make a reasonable disclosure to his patient of the nature and probable consequences of a contemplated treatment and make a reasonable disclosure of the dangers incident to or possible in such treatment. Where such disclosure might in fact be harmful to the patient the decision must be left to the physician's professional judgment. In such a case there is no specific rule, it is a matter for expert testimony as to the standard of the physician's medical community.

## 4. DETERMINATION OF REASONABLENESS OF CONTINGENT ATTORNEY FEES

Section 25 of H.F. 803 provides that in a medical malpractice case the court "shall determine the reasonableness of any contingent fee arrangement between the plaintiff and the plaintiff's attorney."

The Iowa Supreme Court has long exercised its inherent power to inquire into the reasonableness of an attorney's contingent fee arrangement with his client upon application of the client. However, the question has not arisen with any frequency.

The new statute requires the trial court in each medical malpractice case to make a determination as to the reasonableness of any contingent attorney fee arrangement. In each medical malpractice case the attorney's contingent fee arrangement will be scrutinized by the court and will be a matter of public record.

## 5. STATUTE OF LIMITATIONS

Section 26 of H.F. 803 adds a new special statute of limitations for medical malpractice actions which declares in part:

*". . . , within two years after the date on which the claimant knew, or through the use of reasonable diligence should have known, or received notice in writing of the existence of, the injury or death for which damages are sought in the action, whichever of the dates occurs first. . . ."*

The applicable Iowa statute of limitations had previously been two years, *not from the date of discovery of the injury, but from the time the injured person knew he had a cause of action, i.e., that the physician was negligent.* [Baines v. Blenderman, 223 N.W.2d 199 (1974)].

The new two-year special statute of limitations starts to run from the date of discovery of the injury.

This new section also provides:

*". . . in no event shall any action be brought more than six years after the date on which occurred the act or omission or occurrence alleged in the action to have been the cause of the injury or death. . . ."*

This is a new limitation. As has been stated, until now the statute did not begin to run until the injured person knew he had a cause of action no matter what the length of time since the operation, treatment or examination. Under the new special statute no suit can be brought more than six years after the date of the alleged negligent operation, treatment or examination even though the injury has not been discovered.

The new special statute of limitations is in two parts: (1) two years from the date of discovery of the injury; (2) but not more than six years from the occurrence. There are, however, several exceptions to the new special statute of limitations.

1. The first is an exception on the six year statute of limitations. The six year statute does not run if *". . . a foreign object unintentionally left in the body caused the injury or death."*

2. The new special statute of limitations was made a part of the existing chapter on Limitations of Actions (Ch. 614) rather than a separate section in Chapter 147 on regulation of health care professions as originally drafted, therefore minors and mentally ill persons have one year to commence suit from the time they come of age in the case of minors (18 years old) or recover from their mental illness so as to be competent in the case of the mentally ill. (Section 614.8, 1975 Code of Iowa).

3. The doctrine of "fraudulent concealment" is applicable. The statute of limitations will not start to run if the fact of the injury is known to the defendant and he conceals it from the injured party. [Schnebly v. Baker, 217 N.W.2d 708 (1974)]. Further, a physician owes his patient a fiduciary duty (Baines, supra), therefore, he has a duty to disclose the injury—suppression or concealment of the fact of the injury may constitute fraudulent concealment which would prevent the statute

from running. [Price v. Peterson, 173 N.W.2d 549 (1970)].

4. As previously stated, the new special statute was added to Chapter 614, the existing chapter on limitations of actions. Section 614.9 provides for an additional year to bring suit if the person having the cause of action dies before the expiration of the period of the statute of limitations. Thus, if a person has a cause of action for personal injury on account of malpractice and dies prior to the expiration of the period of limitation provided for in the special statute of limitations, his estate will have one year from the date of death to file suit.

## 6. ELIMINATION OF DOLLAR AMOUNT IN AD DAMNUM CLAUSE

Section 27 of H.F. 803 provides that in a medical malpractice action the amount of money damages claimed shall not be stated in the petition.

Prior to the enactment of H.F. 803, Iowa Rule of Civil Procedure No. 70 required that the petition state the amount of money claimed.

The elimination of the amount of money damages claimed in the petition's ad damnum clause was a recommendation in the Report of the Commission on Medical Malpractice (HEW) (1973). It is the opinion of many who have studied the professional liability problem this will help to reduce the inflammatory publicity exorbitant suits receive.

It does, however, create a special problem for a physician who is sued. Because he will not know initially the amount of damages being claimed he will not know whether the amount of money damages which could be awarded might exceed the amount of his primary insurance coverage. *Whenever a claim is made against a physician (or an incident occurs which could give rise to a claim) or whenever a suit is brought against a physician, he should immediately notify his primary insurance carrier, and his excess insurance carrier (or carriers) and any umbrella carrier with whom he may have malpractice coverage regardless of his opinion as to the seriousness of the suit.* Failure to notify all insurance carriers could result in a loss of coverage in the suit.

# SURGICAL TREATMENT OF OBESITY

At its meeting on October 22, 1975, the IMS Executive Council reaffirmed a previous position regarding the surgical treatment (jejuno-ileostomy) of obesity. Four criteria are to be met in the consideration of this procedure, according to the policy statement:

1. A complete psychiatric evaluation and consultation to determine patient motivation and intellectual capacity for success in long-term follow-up.

2. A complete medical work-up, consultation, and evaluation of the need for surgery.

3. The patient should be at least 25 years of age with the exception of those who have compelling complications of obesity such as skeletal problems, severe heart conditions or diabetes. In cases where obesity surgery (jejuno-ileostomy) is deemed necessary, the procedure, felt currently to be purely experimental, should be done only in a university medical center until such time as long-term follow-up reports are available.

4. The patient's weight should be at least two times the ideal weight according to the mean weight of the medium frame on the Metropolitan weight scale. The patient should have been at this weight for at least five years and refractory to medical therapy for at least three years.

The Council also reaffirmed a prior position of the Committee on Medical Service that this subject be reconsidered only in the event of new scientific evidence, thoroughly evaluated by an evenly balanced subcommittee. It was decided further that a special subcommittee should review all of the cases done so far in this state and have up-to-date mortality and morbidity figures as part of this evaluation.

# Blue Cross-Blue Shield Now Under One Roof

*Blue Cross/Blue Shield has become a major tenant in Des Moines' new Ruan Center. The move brings all BC/BS employees under one roof. Noted here are several examples of how the new setting will provide better service for providers and subscribers.*

Blue Cross and Blue Shield of Iowa use the theme "one resource you can depend on" to characterize the services they provide their health care subscribers. Unfortunately, prior to 1975, the largest resource of the Plans—the work force—was scattered in multiple locations throughout the city of Des Moines. To solve the inevitable problems which arise when employees are physically separated, Blue Cross and Blue Shield of Iowa have moved totally into the Ruan Center. This new 36-story structure in downtown Des Moines combines weathering COR-TEN steel, glass, travertine and granite to create a totally modern business environment.

"Until the Ruan Center was built, our effort to serve subscribers and providers was hampered by the fact that no single available building in Des Moines could house our employees," explains William Recknor, Executive Director of Iowa Blue Shield.

This separation of manpower necessitated the costly movement of literally tons of paperwork and hundreds of people between five buildings. Each day delivery trucks transported an average of 240,000 pieces of mail, forms and other internal communications between the various locations.

Occupancy of the Ruan Center took place gradually between March 15 and June 23, 1975. Its culmination marked the first time in 9 years that Blue Cross and Blue Shield of Iowa employees have worked together under one roof. "The 12 contiguous floors occupied here stand in sharp contrast to all or most of the 18 floors occupied in as many as five different buildings since 1966," said Recknor.

Currently, the Plans rent space on Floors 10 through 21 in the Ruan Center, plus space on the entrance level for Subscriber Services.

The decision to move to the Ruan Center followed exhaustive study by staff members and by a consultant with expertise in corporate housing. The studies concluded the Plans would achieve sharply increased employee productivity, plus a definite cost efficiency in a single location.

"We were impressed by a study done by an independent consultant which indicated that as a bellwether tenant, it was more cost efficient for us to rent rather than build," said David Neugent, President of Blue Cross of Iowa. "The cost efficiency of our move is illustrated by the fact that the annual rental cost in the Ruan Center amounts to less than one-half of one percent of the Plans' annual business volume."

The Ruan Center utilizes the most advanced technology in building design, including a computerized control center on first floor to monitor fire, safety, security and environmental systems. Structurally, the Center is as fire proof as any high rise, rigid frame building can be. An extensive sprinkler system supplements the sprayed-on mineral-based fireproofing. An architectural requirement that building materials meet the highest level of fire resistance was followed by the general contractor and by Blue Cross and Blue Shield of Iowa. Smoke and fire detectors are located throughout the core of the building and in pre-selected spaces in the office area. An audio warning capability is available through the speaker system, which can be directed to a single floor or to the entire building.

### COMPUTER PRECAUTIONS

Because of the importance of the computer to the operation of the Plans, special security and fire precautions have been taken for the computer area. Entrance to the computer room can be gained only through the use of a security card plus a four digit security code. Unauthorized

personnel can gain entry only when accompanied by a card holder.

The Halon fire prevention system inside the computer room has the capability to extinguish a fire in five seconds. Activated by the slightest trace of smoke or flame, the highly pressurized Halon gas (which is not noxious to humans) is emitted from a balloon-like structure located in selected areas in the room.

A computerized Honeywell building management system supervises the fire, safety, security, elevator and mechanical systems for the entire building. For example, the system can tell when an air conditioning filter is dirty, where the night watchmen are or aren't, and when and where there is a sudden rise or decline in temperature.

### PLANNED OCCUPANCY

Occupancy of the Ruan Center was planned for three years to assure that every square foot of space would be used effectively. The work flow has been carefully and logically organized so related departments adjoin or are in close proximity to each other, thereby assuring minimum movement of people and papers between floors. For example, the Provider Services and Subscriber Services departments are in an adjoining area on the eleventh floor. Input from both departments is readily available to draw upon in answering inquiries. Also on the same floor with Provider Services is the Medical Division, which again facilitates the work flow that logically passes between these two departments.

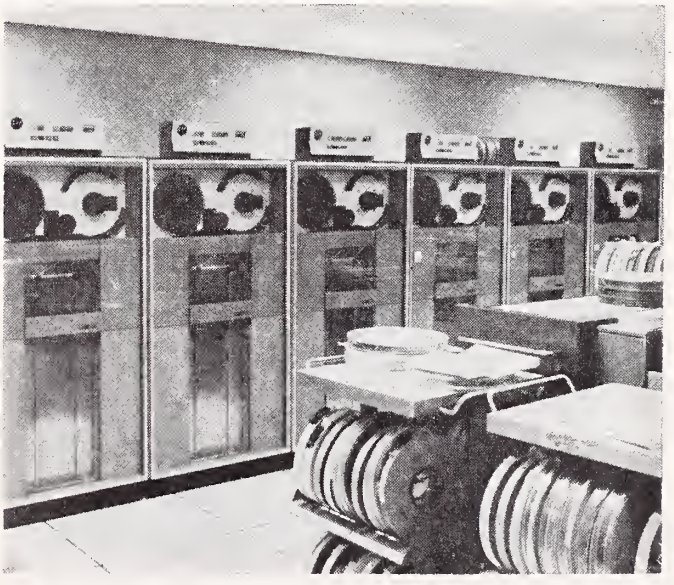
The building's alignment has been established for built-in departmental expansion. For example, a small self-contained department can be moved should a larger department in adjoining space need room to expand. The Blue Cross and Blue Shield lease contains the option to acquire two additional floors (an important option if national health insurance becomes a reality), or the option to give up two floors. "This flexibility is important to us, particularly at this time," said Neugent.

### PROVIDER SERVICES

In the Provider Services Department, which handles approximately 4,000 contacts per week with physicians and hospitals, the specialists have been consolidated by departmental function. For example, certain specialists handle Blue Cross inquiries only, others handle Blue Shield inquiries, and others work only on Part B Medicare. Within this structure each specialist is assigned

MEDICAL REVIEW—Wayne Severson, M.D., left, Vice President of Medical Affairs, discusses claims sent to the Medical Division for review with J. D. Anderson, M.D., center, Associate Medical Officer, and Mary Heggen, manager of Medical Review.

COMPUTER INFO—A computer operator, seated at the communications terminal between the computer and the operator, reads data supplied by the computer.



TECHNOLOGY—Pictured are the magnetic tape drives used for storing and reading data. For example, all claims paid during the past five years are recorded on these tapes for use in rating and research.

CLAIMS HANDLING—This is a partial view of the 118 claims examiners at Blue Cross and Blue Shield. The department recently has reduced its inventory of claims on hand to an all-time low of under 25,000 claims.

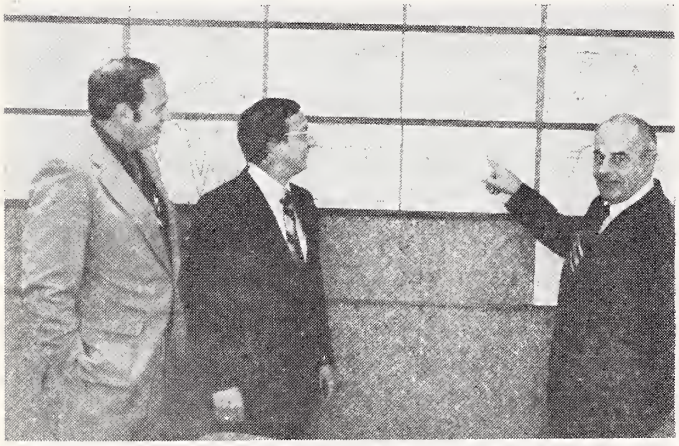
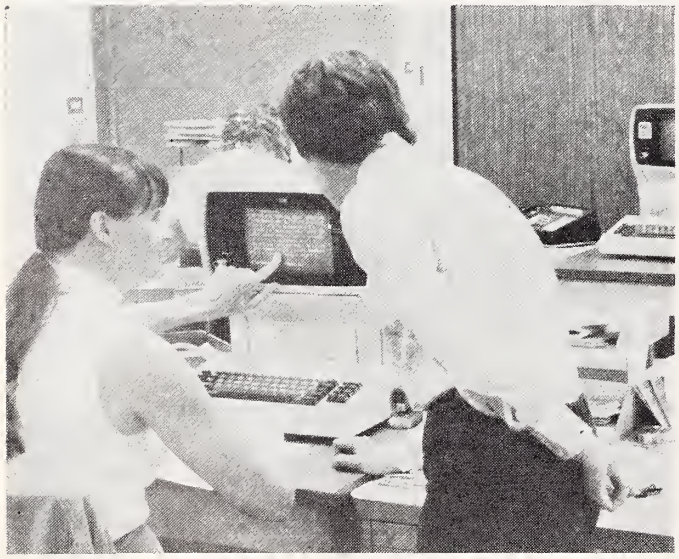


CHART ROOM—David Neugent (right), President of Blue Cross of Iowa, William Recknor (left), Executive Director of Blue Shield of Iowa, and Robert Simmons (center), Vice President of Provider Relations and Alternate Delivery, discuss the progress of the Plans recorded on one of the many graphs included in the Chart Room on the 21st floor.



DISCUSS INQUIRY—Blue Shield information specialists in Provider Services discuss an inquiry from a physician's office. The floor space in the Ruan Center has been organized so that CRT units are located closer to the specialists.

alphabetically to a certain number of doctors and hospitals so that each provider has one contact person in Provider Services. This type of specialized organization allows the information specialist to spot patterns, to become familiar with providers' problems and to avoid duplication.

Like many operations within the Plans, the Provider Services Department is highly computerized via CRT tubes to provide instantaneous display of requested information. Specifically, over 90% of the telephone inquiries regarding regular lines of business are answered on the first contact through the computerized reference system.

### MEDICAL AFFAIRS

In the Medical Affairs Department, Wayne Severson, M.D., describes the advantages of the Ruan Center in a single word . . . "proximity." He added, "The Ruan Center brings the people and the problems closer together for a more speedy resolution."

As an example, the nurse examiners (three for Medical Review and four for Hospital Review) who report to Dr. Severson are in close proximity to the Provider Relations Department and to others within the Medical Affairs Department. These nurse examiners review approximately 15,000 claims per month for determination as to medical necessity, diagnostic admission, medical emergencies and underwriting problems.

### CLAIMS DEPARTMENT

An area that highlights the success of the effort to consolidate the work force is the Claims Department. Consisting of 118 examiners, this department has reduced its claim inventory for regular lines of coverage to an all-time low of under 25,000 claims, a figure reached in the middle of September. The July 1 inventory of claims pending or awaiting action was 46,875. Another indication of the department's improved service is the number of days' work on hand, which for Blue Shield claims has been reduced from 11 days on June 30, 1975, to 5.9 days at the end of September.

The mammoth move of 118 claims examiners and their equipment took only four hours. The computer, which was moved at the same time as the Claims Department, was down at noon on Friday, June 15. However, by the next Monday morning, the department was functioning as usual with access to the computer though live CRT terminals. Consequently, the claims examiners

lost only one half day of productive computer time as a result of the move. The fact that the corporation as a whole received eight hours of productive computer time on Sunday exemplifies the planning involved in moving this complex piece of equipment.

The Training Department provides essential services to physicians' office personnel and to hospitals. It has been designed for convenience and efficiency in its new setting. Four training rooms are available, all containing rear projection booths. Electric dividing doors between rooms provide expansion capabilities. The area also houses the visual aids room and the corporate library.

In the past year, 56 classes have been conducted for employees on topics ranging from medical terminology to management techniques. The goal of this is to prepare some 535 trainees to serve the BC/BS providers and subscribers efficiently. In addition, in-house workshops are held for hospital billing clerks on a quarterly basis and for personnel in skilled nursing facilities and home health centers on an annual basis. Workshops are held in 20 locations throughout the state for medical assistants and secretaries.

### EXECUTIVE OFFICES

The twenty-first floor houses the offices of the senior staff and the legal and marketing departments. Floor space has been planned so conference rooms adjoin the offices of senior staff members. The offices of the two chief executives are connected by a chart room containing approximately 50 charts to detail the progress of the corporation on all lines of business. The floor contains a central filing system to maximize efficiency and to conserve floor space.

The Plans also occupy space on the first floor for Subscriber Services. Walk-in inquiries are easily accommodated through a direct entry off Grand Avenue. CRT units are available for instant access to subscriber records.

Other conveniences have been planned for the operating efficiency of the building as a whole. The U. S. Post Office will operate a substation on Lower Level 1 to serve the building. Mail will be sorted by employees and directly dispatched to its destination without being routed to the Main Post Office. Because we send approximately 40,000 pieces of mail daily, direct service by the postal system is an important step to improving service. United Parcel Service is also planning a pick-up station on Lower Level 1.

There are many other features that make the new Ruan Center a fully modern business structure. However, it has been accepted by Blue Cross and Blue Shield as more than a new home —it also affords an opportunity for a recommitment to people—employees, providers and subscribers. And that's not surprising. In the "people helping people" business that is Blue Cross and Blue Shield of Iowa, that's the way it has to be.

## QUESTION BOX

*(Continued from page 491)*

ing 25 residents giving us a total of 104 residents presently training to become highly skilled family physicians. It's quite a change from no family practice residents five years ago (although there were general practitioners in training at Broadlawns Hospital), and we are proud of the results —we hope the Iowa Medical Society is also.

**Is the interest in family practice among medical students still holding strong?**

Many of us, initially, feared that the strong student interest in Family Practice was a temporary movement motivated by social consciousness. The strong effort by the Board of Family Practice, the American Academy of Family Physicians, and the AMA to establish and maintain high quality programs, has been at least partly responsible for maintaining this strong student interest. In fact, last year approximately 600 students who applied to Family Practice residency programs could not be accommodated for lack of sufficient resident positions. As more programs develop each year, there will hopefully soon be room for all students who desire a career in Family Practice. Surveys of freshman medical students here at the University of Iowa continue to show that over half of the entering class indicates a preference for a career in family practice. This interest appears to be sustaining itself through to graduation as well.

# Physician-Pharmacist Code Of Understanding

*The following statement was approved by the House of Delegates of the Iowa Pharmaceutical Association on September 7, 1975 and the Executive Council of the Iowa Medical Society on October 22, 1975.*

The physicians and pharmacists of Iowa are cognizant that with the growing inter-relationship of medicine and pharmacy, the two professions are and will be drawn into steadily increasing association. To further serve the health and welfare of the public, it is highly important that the professions of medicine and pharmacy be guided by standards of conduct in their inter-professional activities.

This Code of Understanding is not a pronouncement of law, but constitutes suggested rules of conduct for physicians and pharmacists, subject to the principles of ethics adopted by their respective professional organizations, and rules of law prescribed for their individual conduct.

## PRESCRIBING MEDICATION

A prescription is a continuation of the physician's personal diagnosis and treatment of the patient's condition. Every effort should be made by physicans to prescribe the most economical medication which meets the medical needs of the patient.

Since many of the drugs prescribed by physicians today are subject to control and regulation by both federal and state laws, it is of the utmost importance that each profession be aware of its statutory obligations and responsibilities in connection with the prescribing and dispensing of these drugs.

Prescriptions cannot legally be renewed by pharmacists unless authorized by prescribing physicians. In prescribing, whether orally or in writing, physicians should give complete and definite refill directions. Pharmacists should recognize that renewing prescriptions constitutes a continuation of the physician's treatment of his patients.

## DISPENSING MEDICATION

Pharmacists recognize their obligation to patients to compound, label, and dispense prescriptions as ordered by physicians. Should occasions arise where pharmacists have questions concerning drug interaction, ingredients, dosage, or directions for use, they should consult the prescribing physicians for clarification and verification prior to dispensing the medication. Inasmuch as the pharmacists' expertise is pharmacy, and not clinical medicine, they should restrict their discussion to mechanisms of drug actions. If there is a question about the therapeutic reason for the prescribed medication, the patient's condition for which it is prescribed, or the physician's course of treatment, pharmacists should suggest that physicians are the proper persons with whom such matters should be discussed.

The freedom or right of the public to self-diagnose and self-medicate is recognized, as is the pharmacist's role in counseling patients, since pharmacists are a first point of professional contact for the self-diagnosing and self-medicating patient. Pharmacists should be encouraged to use all professional knowledge in reaching decisions whether to recommend medication or recommend consultation with a physician.

Pharmacists have the prerogative and responsibility of selecting efficacious and quality drug products in cases where physicians prescribed generically. Physicians and pharmacists should be encouraged to communicate in selecting quality drug products. Pharmacists are encouraged to dis-

cuss their fees freely with patients; likewise physicians are encouraged to discuss their fees freely with their patients. Physicians should not advise patients as to the exact price of a prescription any more than pharmacists should attempt to establish a fee for a physician's service.

## FREEDOM OF CHOICE

It has been long recognized by the professions of medicine and pharmacy that freedom of choice is an essential principle under our free enterprise system. Consequently, both professions should encourage free choice of medical and pharmaceutical services. Agreements or arrangements between physicians and pharmacists which permit the use of secret formulas, coded prescriptions, imprinted prescription blanks, patronage fees, rebates, or gratuities which deny freedom of choice, and which result in the exploitation of the patient, are not in the best interest of the patient.

In the interest of physician-pharmacist relations and service to the public, it is recommended that all prescription blanks bear the statement: "This prescription should be taken to the pharmacy of your choice."

## PHYSICIAN DISPENSING

Physicians are trained to diagnose and treat patients with disease while pharmacists are trained to compound and dispense prescriptions. While both professions recognize there is no prohibition ethically or otherwise against physicians supplying their patients with needed drugs, remedies, or appliances as long as there is no exploitation of the patient, both professions also recognize that drug dispensing by physicians should not occur when adequate routine and emergency pharmaceutical services are readily available.

## PHARMACIES IN GROUP PRACTICE

There are pharmacies in group medical practices. To prevent exploitation of patients, rental fees charged by physicians for space leased by them to pharmacists should be reasonable according to the commonly accepted standards within that community. The following precepts of the Judicial Council of the American Medical Association should be followed in this regard:

*"The rental of space by a physician or group of physicians as a pharmacy should be a fixed one. Were the rental to be based on the amount of business, it might well be argued, and indeed be the case that fee splitting existed. In addition, the temptation would be ever present for the doctor-owner to encourage patients to take their prescriptions to that pharmacy. The evils inherent in such practice are too obvious to be mentioned."*

## CONSIDERATION AND DISPOSITION OF COMPLAINTS OR DISPUTES

Complaints or disputes involving physicians and pharmacists should be referred to the appropriate professional organization, whereupon the complaint will be disposed of according to the bylaws of the association. All complaints submitted or referred to the professional organization should be promptly and adequately processed.

# IMS BC/BS PROGRAM OPEN

Enrollment in the Iowa Medical Society Statewide Physicians Group Program is open in December. This program is available to member physicians, their families and employees and is offered by Blue Cross/Blue Shield.

The 1976 program has been revised to allow two options. The current and comprehensive benefit structure will be available under one option with monthly rates of $27 for single coverage and $70.30 for family coverage. The second option will have a more restricted benefit structure with a single rate of $21.55 and a family rate of $55. Intermixing of the options within a clinic or physician's office will not be possible.

There are approximately 900 participants in the program which was recommended several years ago by the IMS Committee on Group Insurance.

Additional information and enrollment assistance may be obtained by contacting IMS Headquarters.

## MEDICAL MISCELLANY

*(Continued from page 489)*

**PHYSICIAN DIRECTORY . . .** New IMS Directory was sent in mid-November to Society members. Iowa physician listings are alphabetic and geographic by county.

**CONFER WITH NURSES . . .** Society MD-RN Liaison Committee met November 6 with representatives of the Iowa Nurses' Association to review INA proposed changes in the Nurse Practice Act. Questions were raised over certain portions of the proposal. Further joint discussion is planned before the bill is in final form.

**COUNTY MEETINGS . . .** Six visitations by IMS officers to county society meetings are scheduled in December and January. This will bring to 18 the number of such visits since September. IMS officers are available to meet with other county societies. Requests may be directed to Society Headquarters.

**IOWA GRANT . . .** A $200,000 three-year grant from the National Cancer Institute is supporting research into new chemotherapy for men with advanced prostatic cancer who are now being treated at the University of Iowa Hospitals.

**ALTERNATE DELIVERY . . .** Now available to residents of Davis County and patients of Davis County physicians is participation in Rural Health Services. RHS is a nonprofit corporation which offers a broad range of health services to enrollees for a specified monthly payment. Program is administered by Blue Cross/Blue Shield.

**HEALTH PLANNING . . .** Key session in the development of Iowa's Health Systems Agency (HSA) occurred November 17. The meeting involved professional organizations, state agencies, area planning councils, consumer groups, etc. Recommendations of the HSA Interim Board were reviewed in depth. Plans are proceeding to establish official HSA Board in January. County society presidents are being kept informed on HSA developments.

**RECORD ENROLLMENT . . .** At end of September estimated enrollment of new first-year medical students was 14,874 in the 114 U.S. medical schools. This record figure is an increase of 438 over last year. An estimated 13,595 students will receive the M.D. degree next spring.

***IMPORTANT INFORMATION:*** *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

*Indications:* Lomotil is effective as adjunctive therapy in the management of diarrhea.

*Contraindications:* In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

*Warnings:* Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

*Usage in pregnancy:* Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

*Precautions:* Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

*Adverse reactions:* Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

*Dosage and administration:* ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

*Overdosage:* Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

*Dosage forms:* Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

455

# Editorials

M. E. ALBERTS, M.D., Scientific Editor

## CHRISTMAS MUSIC

*The man that hath no music in himself,*
*Nor is not moved with concord of sweet sounds*
*Is fit for treasons, stratagems and spoils*
*Let no such man be trusted.*

WILLIAM SHAKESPEARE (1564-1616)

There is no other season so endowed with the abundance of special music as Christmas. The chorus of children's voices, the tinkling of small bells and the pealing of large bells, along with the vibrant strains from great church organs combine to swell our hearts with joy and wonderment. Yet, are these sounds truly felt by each of us? Are we aware of the meaning of the joys embodied in the music of Christmas?

What is music? One definition is simply, "sounds with rhythm and tone." Sidney Lanier (1842-1881) called music "love in search of a word." I recall a photograph of a deaf child at the time of her first use of a hearing aid. Truly, these first sounds she perceived were music in the fullest sense. The hunter is excited by the far-off sounds of southbound geese. The gurgling and cooing of the infant is music to the mother. The voice of a loved-one by long distance telephone is music. As Ralph Waldo Emerson (1803-1882) expressed it, "The music that can deepest reach, and cure all ills, is cordial speech."

The man who has a taste for music is much more fortunate than the man who does not appreciate the sounds, whatever they may be. The type of music is not so important as the meaning it may have to the listener. Thomas Carlyle (1795-1881) called music the speech of angels. Yet when I hear some forms of hard rock I am sure he would have ascribed that disorganized sound to the devil.

The sounds that can be produced from a great cathedral organ can do wonders to the emotions of the sensitive man. The tone poems from the various combinations of the many organ pipes provide a mood for any occasion. The addition of the bells and chimes fulfills the best that any symphony orchestra can hope to render. Charles Lamb (1775-1834) likened bells to "music nighest bordering upon heaven." So it is appropriate at Christmas when we celebrate the birth of Christ that bells and chimes, mingled with voices in song, remind us of the good in the world. We should cast away the problems of our daily livelihood and reflect upon the meaning of the Season.

Is your heart in the Season, or does your mind sing only of the business side of medicine? Let this season of music cast aside the desires of greed and earthly treasures, and bring forth a resurgence of brotherhood and good will unmatched by any other. In our professional life we have become so engrossed in fears of the government, the board of directors of our hospitals, the insurance companies, malpractice, and even of each other that we make no positive moves without looking over our shoulders to see what dangers lurk in the shadows. What a horrible existence—to live in fear of the present and the future. Man has always had fears for his survival, fears of the elements, of the uncertainties of adversity and the ravages of nuclear war. Yet we carry on; there is survival of the fittest, and one generation succeeds another.

During this Season let us look at ourselves, our

own lives, and all around us. Let the music of this Christmas enter into our hearts and embody us with a spirit that shall carry over into the New Year. Disagreement between factions should be dealt with in such a fashion that happiness for all involved will result. Compromises will be necessary, for we all must live together in this life. We can make it, filled with music, or dull and sad with bitter silence, or noisily without purpose and beauty.—M.E.A.

## AID FOR HOSPITAL LIBRARIES

The quality of services provided by the hospital library is dependent upon many factors. The never-ending requirements for information, the necessary programs of in-service training, and continuing education programs create a mandate for better services from health science libraries at the local level. No library can provide all the books, as well as the available medical journals, but it can provide access. The quality of the hospital library thus is most accurately measured by its ability to deliver information to the physician, not by the size of the faculty, nor the number of volumes on the shelves.

The physicians of Iowa have a unique opportunity to help their local libraries serve the health sciences professions in a most efficient manner. The Iowa State Advisory Committee on Health Science Libraries has been available for several years to provide consultation services to the local libraries. The hospital administrative and medical staff can become aware of the basic ingredients for developing library services which are responsive to the needs of their institution. Information can be obtained about inter-library loan services, current literature awareness services, bibliographic compilation and reference information, as well as MEDLINE. Available through the University of Iowa Health Sciences Library, MEDLINE provides a low cost search of the literature tailored specifically to individual information needs. A free core list of Books and Journals is available. Perhaps your hospital needs consultation services about management of a library, or you may desire to have your library become a member of a consortium to provide more resources for information. Fees are nominal and well within the range of most hospitals.

The constant need for information is paramount in our business of serving patients. Deficiencies in medical communication affect the activities of three million medical and paramedical personnel in the United States. Inefficiency can create an insidious ignorance that proceeds on and on. The State Advisory Committee stands ready to assist all the health science libraries in Iowa. All the libraries are integrally important—the State Medical Library in Des Moines; the University Health Science Library; and your own hospital and nursing school library. Become involved in the welfare of your library. For further aid, communicate with Edwin A. Holtum, Coordinator for Health Sciences Libraries in Iowa, Health Science Library, University of Iowa, Iowa City, Iowa 52242. 319/353-3071.—M.E.A.

# Continuing Education Courses & Conferences

*Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.*

| | |
|---|---|
| Dec. 1-4 | Cardiology Today |
| Dec. 3 | Ophthalmology Clinical Conference |
| Dec. 4 | Conference on Blood Gases and Blood Gas Analysis |
| Dec. 5 | Cardiac and Respiratory Disease Conference |
| Dec. 8 | Modern Concepts in Epilepsy |
| Dec. 10-11 | Conference on Obstetrics and Gynecology |

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| Jan. 7 | Ophthalmology Clinical Conference |
| Jan. 26-30 | Cardiology Today |
| Feb. 4 | Ophthalmology Cinical Conference |
| Feb. 17-20 | Refresher Course for Family Physician |

# Educationally Speaking

by RICHARD M. CAPLAN, M.D.

## WERE YOU TRAINED, OR EDUCATED

Physicians often ask their colleagues, "Where did you take your training?" I can't recall when I may have heard, "Where did you have your education?" Are those key words just synonyms, or may there be an important message lurking in the choice of words?

What differences are there between training and education? The distinction is not always easy to draw. The athlete speaks of being "in training," referring to the development and maintenance of physical power and coordination. A "training school" sometimes refers to a "reformatory" for delinquent or wayward young people. In either usage there's little likelihood of confusion with education.

Training often suggests the process of learning manual or technical skills which we rank as "lower," in contrast to the "higher" skills that involve greater intellectual functioning. Training perhaps involves learning that has more specific objectives, whereas education aims at broader, global, or diffuse objectives. In this regard some wag has said, "If you know what the objectives are, call it training; if not, call it education." Training tends to seek uniformity of its students, while education seeks a maximum of individual difference through the discovery and releasing of the potential of the individual.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

No matter which definition suits you best you likely obtain a sense that education is higher or more worthy than training. To assign hierarchical value, however, is to invite argument, because values relate so much to context and to our basic philosophical stance about what is the good. To say that preparation and maintenance of ourselves as physicians is indeed education rather than training ignores the large amount of our effort that is technical, manual, standard, repetitive, and could well be performed by someone with less education. If someone could be a successful watchmaker, could he not be trained to perform a myringotomy safely and successfully? Ah, but (you argue) to *know when and why* to perform the myringotomy requires education.

Of what then does your *continuing* medical education consist—education or training? You're likely to respond, "both," and I agree that it should. But is it presently heavy on the side of training? Maybe our sensitivity to broader-than-technical concerns needs some special cultivating. For example, if we read or discuss the definition of death as a biomedical phenomenon, should we not also take some pains to study the question as a vital issue in theology, philosophy, law, literature and social policy? Any physician who reads Tolstoy's superb story, "The Death of Ivan Ilych," as I have just done, will gain fresh insight into the nature and significance of a "biomedical" phenomenon. Our lifelong curriculum of medical education needs, in my opinion, more breadth and occasion for reflection, even if it means less effort spent on technical advances. If you have specific disagreement or suggestions, let me hear from you.

# HEALTH PROBLEMS OF VIETNAMESE REFUGEE CHILDREN

With arrival in Iowa of significant numbers of Indochinese refugee families, physicians and other health workers will be asked to evaluate and determine the preventive health needs of the refugee children. The following information may prove helpful.

Upon arrival in the United States, the refugees were placed in one of four military camps designated as primary processing centers. Except for persons arriving and clearing camps in the first two weeks of May, all refugees were subjected to health screening procedures. These procedures included chest x-rays and serologic tests for syphilis (sts) for persons ages 15 years and over, as specified in the federal government's immigration visa requirements. Also initiated was the standard recommended immunization series, as well as screening for tuberculin sensitivity among children ages 2 months through 14 years. A review of the immunization programs and survey results at Camp Pendleton suggests that for the refugee children additional and special attention should be paid to completing adequate "routine" immunizations, plus careful evaluation and treatment of tuberculin sensitivity.

## PREVALENCE OF TUBERCULOSIS

Among adults at Camp Pendleton, California, 21,000 persons ages 15 and over were examined by chest x-ray between May 10 and August 31. This constituted approximately 95% of the persons in this age group passing through the camp in this time period. Of these persons, 6.5% had abnormal chest films. All persons with abnormal chest films were tested for tuberculin sensitivity, asked for a past history of tuberculosis infection, and evaluated for gross signs and symptoms suggestive of tuberculosis. From each of these subjects, two sputum samples were examined for acid-fast bacilli, and 143 persons were found to be positive on smear. This suggests the presence of active, sputum-positive, tuberculosis in at least 0.68% of the adult population, equivalent to a prevalence rate of about 680/100,000. Comparable rates were observed at the other camps. This is markedly higher than the 12/100,000 prevalence rate for all active T.B. observed in Iowa's adult populations during the past five years.

Persons considered to have tuberculosis were started immediately on therapy appropriate to current standards of practice in the U.S. Follow-up care after departure from camp was arranged through standard interstate TB patient-referral procedures. In general, single drug therapy for tuberculin reactivity in the absence of other signs of disease, was *not* initiated during the transient refugee camp situation.

*Tuberculosis Infection Among Children:* All children aged 1 to 14 years were examined for tuberculin sensitivity by the Mantoux technique, using intermediate strength PPD and considering 12 mm or greater of induration as positive. A total of 11% were positive by this criteria. Because BCG vaccination was widely used in Vietnam as a matter of public health policy, a BCG scar survey was added to the tuberculin test reading activity. Of 1,947 children examined in the combined evaluation, approximately half had a scar indicating previous BCG vaccination. Tuberculin positivity rates were 23% among children with a BCG scar and 11% among those without

BCG scars, suggesting that the tuberculin sensitivity in this population could not be attributed reliably to BCG vaccination, but rather should be considered indicative of natural tuberculosis infection.

Children found to be tuberculin positive were examined by chest x-ray and approximately 6% had abnormal chest x-rays. These were further evaluated for active tuberculosis by history, cursory physical examination, and sputum smear examination. Children considered to have active tuberculosis were then placed on appropriate medication, and follow-up care after departure from camp was arranged through standard interstate TB referral procedures. Tuberculin-positive children without evidence of active disease were not placed on prophylactic therapy in the transient refugee camp situation.

### CAMP IMMUNIZATION PROGRAMS

Exact immunimation practices varied somewhat from camp to camp, except for the common effort to deliver at least one dose of DPT, one dose of trivalent oral polio vaccine, and one dose each of measles and rubella vaccine to every child between 1 and 6 years of age. At Camp Pendleton, the DPT and polio vaccines were given from age 3 months through 6 years, Td and polio were given from 6 through 14 years, and measles-rubella vaccines were given from age 1 through 12. At least 95% of arriving refugee children were covered by this program at Pendleton, and other camps had comparable results. Reasonable efforts were made to provide the refugee families with some record of the specific immunizations given, using the standard yellow "International Certificates of Vaccination," a copy of the Immigration and Naturalization Service's "Standard Form #398," and/or a copy of data processing record forms specific to the refugee program.

*Recommended Immunization Follow-up in Iowa:* It is safe to assume that children ages 1 through 6 have received one dose of each of the basic vaccines if the family went through the screening program. If the family came through Camp Pendleton, the more specific standards given above may be applied. If specific records or other information are available to confirm immunization activity, this should be taken into account. In any case, AT LEAST TWO ADDITIONAL DOSES OF DPT AND/OR Td, AND OF TRIVALENT ORAL POLIO VACCINE ARE NECESSARY to assure minimum basic protection for the Vietnamese children. If in doubt, there is no known hazard associated with receiving an extra dose of any of the recommended vaccines.

*Recommended Tuberculin Test Follow-up in Iowa:* ALL TUBERCULIN-POSITIVE CHILDREN should be considered to be infected with the tubercle bacillus and SHOULD BE PLACED ON STANDARD INH PROPHYLACTIC THERAPY to prevent the later development of active tuberculosis. If the family has no record of a child's tuberculin status, the test should be repeated. Because of the high prevalence of active tuberculosis among the adult refugee population, and the crowded living conditions in the refugee camps, it seems reasonable to assume that all childen were at a high risk of contracting tuberculosis infection while in the camps, right up to the day of departure. Since tuberculin sensitivity may require up to three months to develop following infection, FOR CHILDREN SHOWN TO BE TUBERCULIN NEGATIVE ON ARRIVAL AT THE CAMPS, IT IS REASONABLE TO REPEAT THE TUBERCULIN TEST AT THREE MONTHS AFTER DEPARTURE FROM THE CAMP, in order to detect late conversions, indicating infection acquired during the refugee-processing period.

*STS Reactivity and Recommendations:* Serum specimens were taken from all persons ages 15 and over and examined by the RPR screening test for reactivity suggestive of syphilis infection. RPR-positive sera were further examined by quantitative VDRL and FTS-ABS procedures. By RPR screening, 4.3% of adults were positive, and 2.8% of all adult sera were positive by FTA. This RPR positivity rate of 4.3% is somewhat higher than the 1.6% rate for all VDRL examinations done annually in Iowa. FTS-ABS positive sera were considered diagnostic of syphilis infection, and all such positive persons were examined and interviewed to determine the stage of the disease and to identify contacts in the camp population. All children of persons diagnosed as having latent syphilis were examined by appropriate serologic tests in order to detect possible congenital syphilis infection.

The infected persons were then treated with currently recommended drug regimens appropriate to the stage of the disease as determined by the history, physical examination, and quanti-

tive VDRL results. Persons who had already left camp were followed up through standard interstate venereal disease referral practices.

Since appropriate syphilis therapy was given to all FTA-positive individuals at camp and appropriate interstate follow-up procedures were initiated on those who left before therapy was completed, there is no need for general STS screening of refugees on their entry into the general population. This particular population sub-group should be handled the same as the general American population relative to venereal disease.

## Morbidity Report for October, 1975

| Disease | Oct. 1975 | 1975 to Date | 1974 to Date | Most October Cases Reported From These Counties |
|---|---|---|---|---|
| Amebiasis | 2 | 19 | 30 | Boone, Washington |
| Brucellosis | 1 | 1 | 16 | Woodbury |
| Chickenpox | 340 | 7051 | 6743 | Black Hawk, Clayton, Dubuque, Johnson |
| Conjunctivitis | 131 | 1089 | 737 | Scattered |
| Encephalitis | | | | |
| Type, unspecified | 2 | 4 | 14 | Hancock, Washington |
| Viral | 3 | 5 | 17 | Audubon, Linn |
| ECHO 4 | 2 | 5 | 4 | Black Hawk, Jackson |
| ECHO 9 | 2 | | | Hamilton, Johnson |
| Coxsackie B4 | 1 | | | Polk |
| CEV | 4 | 6 | | Allamakee, Clayton, Fayette |
| SLE | 2 | 7 | | Pocahontas, Scott |
| WEE | 2 | 4 | | Lyon, Woodbury |
| Erythema Infectiosum | 18 | 159 | 546 | Bremer, Carroll, Floyd, Jackson, Johnson |
| Gastrointestinal viral infect. | 1712 | 17857 | 9262 | Benton, Bremer, Buchanan, Chickasaw |
| Giardiasis | 4 | 24 | 42 | Clinton, Floyd, Johnson |
| Gullian-Barre Syndrome | 1 | 6 | | Story |
| Hand, Foot and Mouth Disease | 1 | 11 | | Worth |
| Hepatitis | | | | |
| A | 22 | 150 | 230 | Calhoun, Dallas, Iowa, Polk |
| B | 7 | 82 | 76 | Linn, Polk |
| Type unspecified | 2 | 27 | 38 | Black Hawk, Webster |
| Histoplasmosis | 6 | 24 | | Jasper, Johnson, Lee, Polk, Poweshiek |
| Impetigo | 138 | 647 | 463 | Benton, Johnson, Linn, Muscatine |
| Infectious Mononucleosis | 112 | 1004 | 843 | Black Hawk, Lee, Winneshiek |
| Influenza-like illness | 3055 | 41044 | 94894 | Benton, Carroll, Johnson, Linn, Madison |
| Listeriosis | 1 | 1 | 1 | Henry |
| Meningitis | | | | |
| Aseptic | 3 | 10 | 52 | Polk, Pottawattamie |
| assoc/with ECHO 4 | 1 | 3 | 16 | Hamilton |
| due to Coxsackie B4 | 1 | 1 | | Polk |
| Coxsackie | 1 | 1 | | Clayton |
| due to *H. Influenza* | 4 | 16 | | Jackson, Muscatine, Pottawattamie |
| Meningoencephalitis | 1 | 3 | | Clarke |
| assoc/with Mumps | 1 | 1 | | Clinton |
| Myelitis due to Coxsackie | 1 | 1 | | Mahaska |
| Mumps | 89 | 1154 | 1790 | Scattered |
| Pediculosis | 59 | 317 | 424 | Scattered |
| Pertussis | 1 | 4 | 14 | Wapello |
| Pneumonia | 97 | 936 | 953 | Benton, Floyd, Scott |
| Rabies in Animals | 6 | 90 | 112 | Scattered |
| Rheumatic fever | 2 | 13 | 52 | Dubuque, Poweshiek |
| Ringworm, body | 35 | 242 | 187 | Scattered |
| Roseola | 3 | 12 | 15 | Palo Alto, Van Buren |
| Rubeola | 32 | 621 | | Dubuque, Mills |
| Salmonellosis | 20 | 95 | | Scattered |
| Scabies | 136 | 452 | 104 | Black Hawk, Cerro Gordo, Dubuque, Polk |
| Shigellosis S. *sonnei* | 1 | 49 | | Linn |
| Streptococcal infec. | 541 | 7866 | | Jackson, Johnson, Polk |
| Tetanus | 3 | 3 | | Dubuque, Mills, Pottawattamie |
| Toxoplasmosis | 1 | 1 | | Johnson |
| Trichinosis | 1 | 1 | | Scott |
| Tuberculosis | | | | |
| total ill | 10 | 104 | 104 | Scattered |
| bact. positive | 8 | 67 | 11 | Scattered |
| Venereal Diseases | | | | |
| Gonorrhea | 720 | 5881 | 5197 | Black Hawk, Dubuque, Linn, Polk, Scott |
| Syphilis | 21 | 248 | 321 | Scattered |
| Chancroid | 1 | 2 | | Polk |

*Laboratory Virus Diagnosis Without Specified Clinical Syndrome*

| | | | |
|---|---|---|---|
| Adenovirus | 1 | Herpes simplex | 5 |
| Eaton's agent infections | 6 | ECHO 4 infections | 4 |

# Medical Assistants

by TENORA MEYER, CMA

## JEANNE GREEN, NATIONAL VICE-PRESIDENT

Jeanne D. Green, CMA-A, Davenport, Iowa, was elected vice-president of the American Association of Medical Assistants at the 19th annual AAMA convention in October.

Mrs. Green, a medical assistant for 26 years to James F. Bishop, M.D., a proctologist, is responsible for all clinical and administrative work in a one-girl office. The founding president of the Scott County Medical Assistants Chapter of AAMA, Mrs. Green has just completed her fifth term as an AAMA trustee. She has been active in state activities, serving as president, vice-president, secretary and parliamentarian.

Other new officers include Laura L. Lockhart, CMA-A, Ohio, President; Joan C. Michaels, North Carolina, President-Elect, and Dorothy Hartel, CMA-A, Maryland, Secretary-Treasurer. Trustees for 2-year terms include Margaret F. Corcoran, CMA-AC, New Jersey, Luella V. Mitchell, Illinois, Jean Mobley, CMA-AC, Texas; Dorothy Sellars, Virginia, and Mabel Ann Veech, Kentucky.

## CONVENTION HIGHLIGHTS

Approximately 1,000 medical assistants attended. A delegation was present from Ontario, Canada, representing the Ontario Medical Secretarial Association. The education program included topics on legislation and credentialing, Future of Health Care, Fitness for Busy People, Hypertension, Rheumatoid Disease and Emergency Medicine.

Special workshops were held for CMA's and educators, as well as general workshops on gynecology, hypertension, ophthalmology, pediatrics and surgery. There were also workshops on communication, parliamentary procedure, the procedure manual, nutrition, practice management, guided study and oral presentations.

A 1975 Reel Review included the following Audio-Visual Program Resources available at this time:

**Food and Fitness** (Blue Cross-Blue Shield, Delta Dental, Kentucky) 35 mm. slide/sound presentation on nutrition and physical fitness.

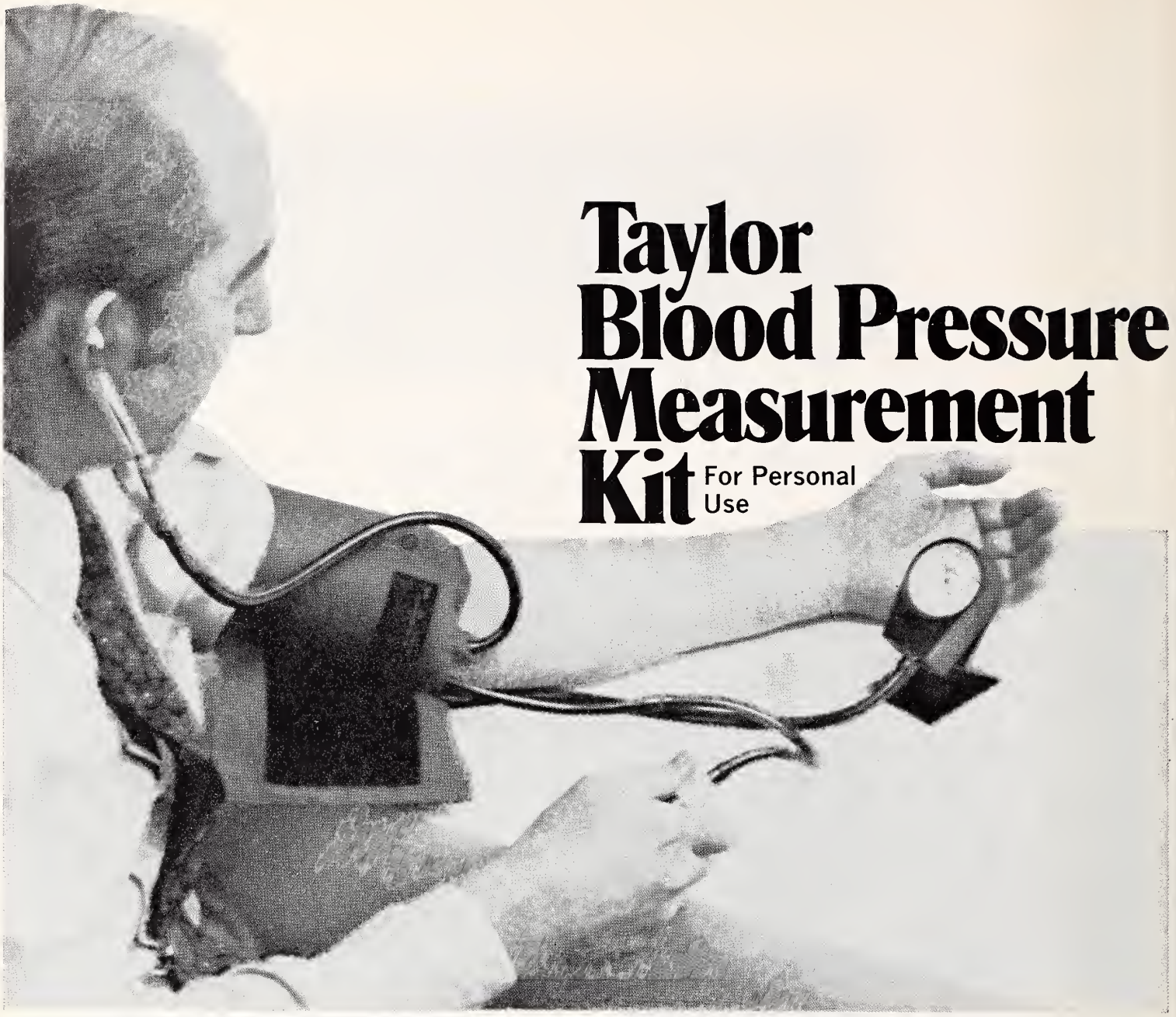
**Short Term Visual Memory** (Bell Telephone Co.) 16 mm black/white sound film story of interesting Bell telephone laboratory experiments in perception and erasure processes of visual perception.

**Urinalysis in the 70's** (Ames Company) 16 mm color sound documentary film presents the views of six medical and clinical professionals in laboratories and clinics throughout the world. Topics include: the importance of urinalysis, the physiology of urine and urine sediment, the chemistry of reagent strips and the significance of various substances found in the urine.

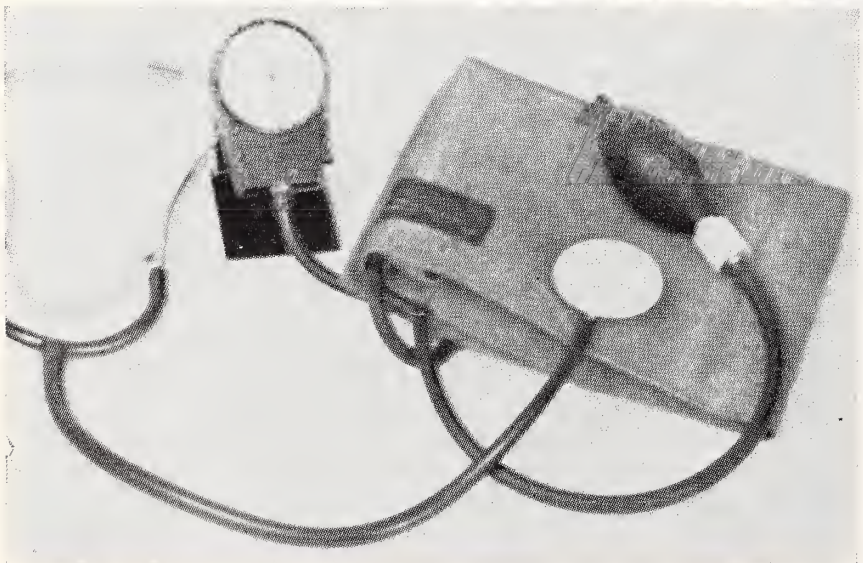
**Lady Beware** (Pyramid Films) 16 mm color sound film that demonstrates effective common sense techniques that women can employ to protect themselves from the growing menace of personal assault. The film was made in cooperation with the Los Angeles Police Department.

**New Pulse of Life** (Pyramid Films) 16 mm color sound training film on cardiopulmonary resuscitation (CPR) based on "Standards for Car-

*(Please turn to page 519)*



# Taylor Blood Pressure Measurement Kit For Personal Use



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# About IOWA Physicians

**Dr. James O. Stallings,** Des Moines, was guest speaker at recent meeting of Skiff Hospital Auxiliary in Newton. Dr. Stallings spoke on cosmetic and reconstructive surgery. . . . **Dr. Robert F. Godwin** recently opened an office for the practice of dermatology in Davenport. A graduate of U. of I. College of Medicine, Dr. Godwin was formerly in private practice in Sioux City. . . . **Dr. Opas Anothayanontha** has closed his medical practice in Traer. . . . **Dr. John Beattie,** Creston, was the guest speaker at annual dinner meeting of Dallas County Hospital Auxiliary. Dr. Beattie's topic: "Doctors, Dolls and DCH."

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**Dr. Thomas Altemeier** will begin a family practice in Iowa Falls after completing his family practice residency in April, 1976, at Broadlawns Hospital in Des Moines. A native of Newton, Dr. Altemeier graduated from Luther College in Decorah and received the M.D. degree at U. of I. College of Medicine. . . . **Dr. Carleton T. Helseth,** Sioux City, was re-elected Sioux City Community School District Director. This is Dr. Helseth's third term. . . . **Dr. Gary Lawrence,** Ackley, has been admitted to Fellowship of American College of Anesthesiologists. . . . **Dr. Donald L. Trefz,** Charles City, has been appointed by Governor Robert Ray to Comprehensive Health Planning Advisor Council. . . . **Dr. Donald C. Berge** has joined **Drs. J. Y. Hendricks, R. L. Borgman,** and **S. A. Moeller** in the family practice of medicine in Clear Lake. . . . **Dr. Jed Paul,** Creston, was the guest speaker at recent Creston Rotary Club meeting. Dr. Paul spoke on Zeroradiography now being used at Greater Community Hospital in Creston. . . . **Dr. Reynold Maixner,** Logan, attended a recent family practice refresher course at University of Nebraska Medical Center in Omaha. . . . **Dr. E. B. Wilcox,** Oskaloosa, was honored by fellow Kiwanians on his 98th birthday. He is a charter member of the Oskaloosa Kiwanis Club. . . . **Dr. Barry E. Knapp,** Sioux City, was guest speaker at September meeting of Operating Room Nurses' Association in Sioux City.

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**Dr. David L. Little** has joined Department of Pediatrics at Park Clinic in Mason City. Dr. Little received the M.D. degree at University of Nebraska; interned at Lincoln General Hospital in Lincoln, Nebraska; and served his residency at Navy Hospitals in Bethesda, Maryland, and Charleston, South Carolina. . . . **Dr. Theodore Scurletis,** medical director of Maternal and Child Health Section, Iowa Department of Health, was guest speaker at recent board of directors meeting of Community Health Care, Inc. in Davenport. His topic "What Are Comprehensive Health Services for Children?" . . . **Dr. M. D. Hayden,** Cherokee, participated in planning of first Consumer Health Education Fair sponsored by Cherokee County Board of Health and Public Health Nursing Service.

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**Dr. J. C. Bhalerao,** cardiologist, has joined Medical Associates in Clinton. Dr. Bhalerao received his medical education in India; his residency in internal medicine and fellowship in cardiology were taken in Chicago. For the past year, Dr. Bhalerao has been a teaching assistant at University of Illinois. . . . **Dr. Truce Ordona,** Davenport, and **Dr. Harry Mahannah,** Bloomfield, were guest speakers at a recent seminar on child abuse at Indian Hills Community College in Ottumwa. . . . **Dr. J. J. Young,** Clinton, was named boss of the year by Clinton Progress Charter Chapter of American Business Women's Association. Dr. Young is plant physician at E. I. DuPont. . . . **Dr. J. T. Mangan,** family practitioner in Forest City since 1949, will join the Mayo Clinic in Rochester, Minnesota, January 1, 1976. Dr. Mangan will be affiliated with the Division of Family Medicine,

# IN PURSUIT OF GOOD PHYSICIAN/HOSPITAL RELATIONS

IOWA PHYSICIANS affiliate themselves in various ways as they pursue the care and treatment of their patients. These associations differ in nature and formality, but each is of consequence.

Of principal significance is the physician's medical staff affiliation with one or more hospitals. There are other important associations, e.g., county and state medical societies, specialty groups, etc. Through each of these mechanisms the Iowa physician seeks to promote and establish the kind of practice setting where he can serve effectively.

The Iowa Medical Society encourages and supports its member physicians as they interact with health institutions, facilities and programs. For example, the Society this year has updated and increased its reference capability with a document entitled *Guides for Relations Between Physicians and Hospitals—1975*. This has been prepared by IMS legal counsel. Also in hand for reference use is *Physician-Hospital Relations/1974,* a document approved by the American Medical Association House of Delegates.

What's covered in the IMS Physician/Hospital Guides? A variety of topics including: (1) Basic Legal Principles, (2) Policy Guidelines in General, (3) Guidelines for Specific Hospital/Physician Relations, (4) Medical Staff Membership and Privileges, and (5) Relationships Between Medical Staffs and Hospital Governing Boards. Here are brief highlights from the Guides:

Basic Legal Principles—The statutory rights to practice medicine are set forth in Chapters 147 and 148 of the Iowa Code. Noted is the fact that only a licensed *individual* may practice medicine. In addition to the statutes, Iowa common law or judge-made rulings have an impact on the way medicine is practiced. For example, common law allows the delegation of aspects of practice to qualified persons acting under the physician's direction and supervision. Further, the common law, as represented by the corporate practice rule, says in essence that corporations and unlicensed individuals cannot engage in medical practice. The several exceptions to the corporate practice rule are summarized in the IMS Guides.

Policy Guidelines—Various general policies apply in the arrangements which are developed between physicians and hospitals. For example, (a) professional services of a physician should not be disposed of to a hospital, corporation or lay body which in turn sells them for a fee, (b) any contract wherein a hospital acts as an agent for a physician should be ethical and have the consent of the doctor and the medical staff, and (c) teaching, research and administrative duties performed by a physician in a hospital may be on any mutually satisfactory basis.

Specific Hospital/Physician Relationships—Certain medical specialties, i.e., anesthesiology, pathology, physical medicine and radiology, have an institutional nature to them. This requires careful attention by the physicians in these specialties and the hospitals in which they serve. It is important for the services of these practitioners to be regarded in all aspects as medical services. There are other institutional elements which need careful attention as to their organization and operation, e.g., emergency medical departments, graduate medical education programs, etc.

Medical Staff Memberships—In becoming members of hospital medical staffs, physicians must agree to certain rules and regulations. Staff privileges hinge on compliance with these rules. Thus, the medical staff has a fundamental and principal role in the maintenance of quality care within an institution.

Relations Between Medical Staffs and Hospital Governing Boards—Organized medical staffs establish their bylaws, rules, etc., subject to approval by the governing body. This approval authority should be used with judiciousness and not as an arbitrary mechanism. Similarly, the medical staff must make vigilant effort to see that its by-laws are followed by all members.

These thoughts have been adapted from Iowa Medical Society reference materials which are being provided to hospital chiefs of staff and other interested physicians. They underscore the need for active participation by the medical profession in the development of those procedures and contracts which govern the delivery of patient care.

# IN THE PUBLIC INTEREST

serving in the clinic's satellite health care facilities. He will also work in the Division of Education, along with resident doctors and medical students interested in family practice specialty. . . . **Dr. Larry W. Lawhorne,** third-year resident in the U. of I. Department of Family Practice, has received a certificate from the American Academy of Family Practice recognizing his scholastic achievement. Last year, Dr. Lawhorne was one of 15 young physicians in the nation selected by the Academy to receive a $1,200 award under a scholarship program established in 1952.

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The following U. of I. College of Medicine faculty members were program participants at a recent Waterloo Cancer Conference—**Dr. John W. Berg,** professor of preventive medicine; **Dr. Michael P. Corder,** assistant professor of internal medicine; **Dr. Peter R. Jochimsen,** assistant professor of surgery and **Dr. Howard B. Latourette,** professor of radiology. The conference sponsors were U. of I. College of Medicine; the Waterloo Postgraduate Education Committee; Mayo Foundation; the American Cancer Society and the Iowa State Cancer Registry. . . . **Dr. T. J. Egan,** Bancroft, was honored by Bancroft Chamber of Commerce for his 40 years of medical service to the community. . . . **Dr. Walter M. Block,** medical director of Child Evaluation Clinic in Cedar Rapids, was guest speaker at a recent Kansas City Research Hospital staff meeting. Dr. Block spoke on "Cerebral Dysfunctions in Children." . . . **Dr. Robert T. Soper,** professor of surgery at U. of I. College of Medicine, is one of three authors of a textbook on pediatric surgery which has recently been published in English and German. The English version is entitled, "Synopsis of Pediatric Surgery"; the German title is "Kinderchirurgie." . . . **Dr. Stephen C. Gleason,** D.O. has joined **Dr. Roy W. Overton** in family practice in West Des Moines. A Des Moines native, Dr. Gleason was valedictorian of his graduating class at the College of Osteopathic Medicine and Surgery in Des Moines and completed his family practice residency at Memorial Medical Center in Corpus Christi, Texas. . . . **Dr. Charles Reed,** professor of pediatrics at U. of I. College of Medicine, was guest speaker at recent Waterloo meeting of Diabetes Association. His topic, "Coping With Diabetes."

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**Dr. Jack Moyers,** head of the Department of Anesthesia at U. of I. College of Medicine, was named first vice-president of American Society of Anesthesiologists at recent annual ASA meeting in Chicago. . . . **Dr. John G. Gschwendtner,** Dubuque, has been named a Fellow of the American College of Surgeons. . . . **Dr. James Paulson,** Grinnell, is medical supervisor of the emergency medical technician class being conducted at Grinnell General Hospital. . . . **Dr. Robert Singer,** Waterloo, has been appointed medical director of the Black Hawk County Drug Council. . . . **Dr. Loraine Frost,** Iowa City pediatrician for the past 25 years, retired in October. Dr. Frost received the M.D. degree at Women's Medical College in Philadelphia and completed her pediatric residency at University Hospitals in Iowa City. . . . **Dr. D. Kuper,** Council Bluffs, and **Dr. Keith Swanson,** Atlantic, were guest speakers at a recent seminar in Atlantic for nurses and physicians on urinary infections. . . . **Dr. R. H. Palmer,** Postville, was awarded degree of Fellow at recent annual meeting of American Academy of Family Physicians. Dr. Palmer is also a charter member of Academy . . . **Dr. Frederic Roules,** Mediapolis, was guest speaker at recent seminar for RN's in Lee, Louisa and Des Moines counties. Dr. Roules spoke on diabetes and treatment.


# MEDICAL CONGRESS IN NASSAU

**The First American-German Postgraduate Medical Congress will take place between December 26, 1975 and January 9, 1976 at the Holiday Inn in Nassau followed by a Caribbean cruise. Fifteen qualified University Professors from the United States and Germany, all bilingual, will participate in teaching seminars recommended for practicing physicians, internists, cardiologists, family physicians.**

**Further details may be obtained by writing to:**

**S. Heyden, M.D.**
**Department of Community Health Sciences**
**Duke University Medical Center**
**Durham, North Carolina 27710**

**Dr. John Doran,** Ames, was guest speaker at Marshalltown Community College convocation on sex education. . . . **Dr. Bernard C. Hillyer** has joined the Medical Center in Atlantic. A 1970 graduate of University of Nebraska School of Medicine, Dr. Hillyer interned at Sacred Heart Hospital in Spokane, Washington; served two years in the Army; and had two years of orthopedic residency at Wichita, Kansas. . . . **Dr. R. E. Weland,** Cedar Rapids, spoke at recent meeting of Manchester Lions Club on blood collection and use. . . . **Dr. Glen E. Nielsen,** Des Moines, has been named medical director of The Bankers Life. Dr. Nielsen has served as assistant medical director of the company since 1963. . . . **Drs. Ramon** and **Christina Yaldau,** former Forest City physicians, recently opened the Yaldau Clinic in West Des Moines. Dr. Ramon Yaldau is a family practitioner and Dr. Christina Yaldau specializes in obstetrics and gynecology. Both doctors received their M.D. degrees at University of Santo Tomas, Manila, Philippines, and interned at Iowa Lutheran Hospital in Des Moines. . . . **Dr. Robert L. Mandsager,** Marshalltown, was guest speaker at Annual Mission Festival of Bethany United Church of Christ in Baxter. Dr. Mandsager gave a slide presentation on his mission work in Cameroun, Africa, where he served from 1954 to 1964 as a medical missionary. . . . **Dr. James F. Bishop,** Davenport, president-elect of Iowa Medical Society, was guest speaker at November meeting of Wapello County Medical Society. . . . **Dr. John Tyrrell,** Manchester, was recently appointed chairman of the Health Systems Agency transition committee of the Hoover Health Council.

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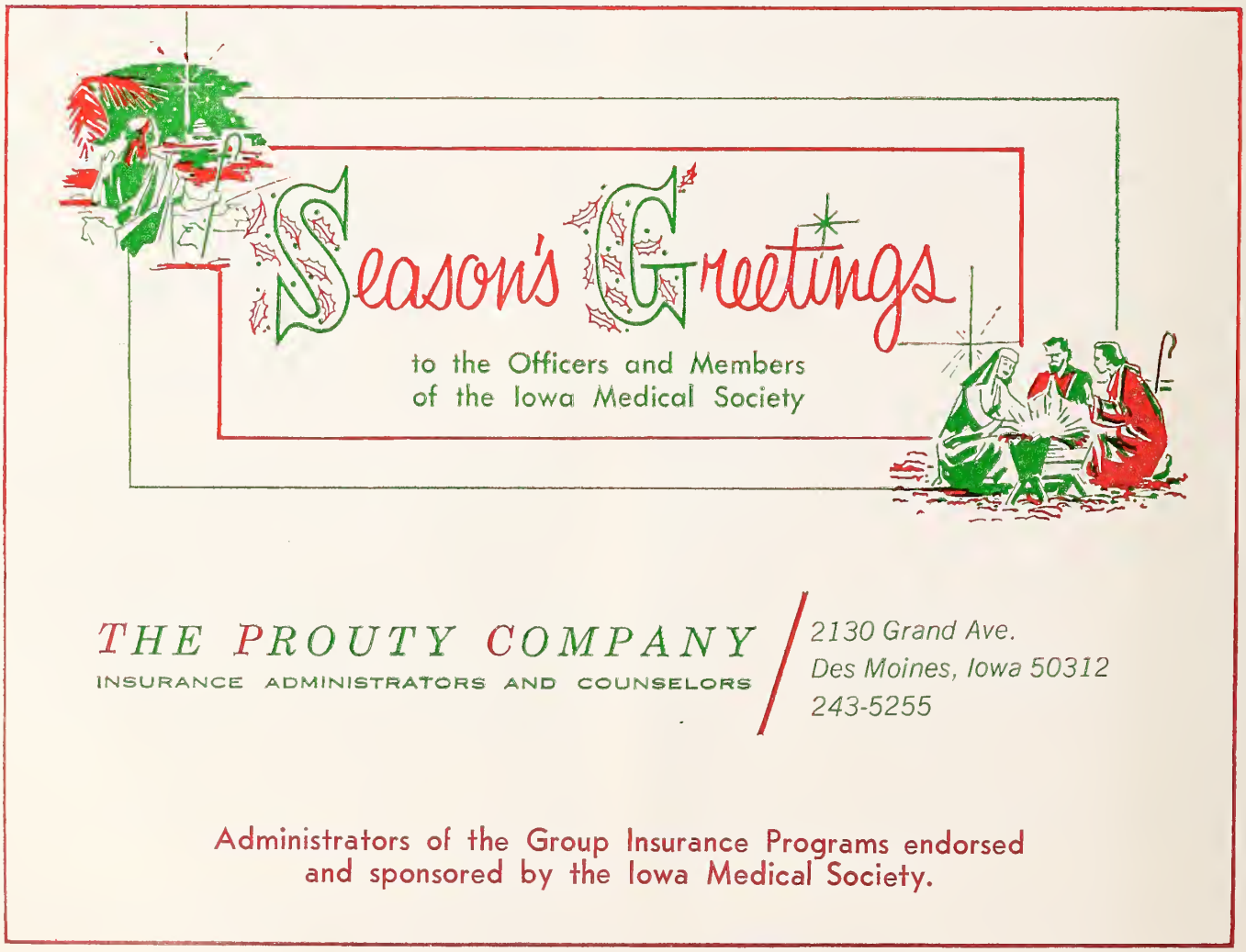
**Dr. Marshall Flapan,** Des Moines, was named 1975 Boss of the Year by Des Moines Chapter, American Association of Medical Assistants.



# JOURNAL/IOWA MEDICAL SOCIETY INDEX TO VOLUME LXV NUMBERS 1-12 (1975)


About Iowa Physicians 33, 71, 157, 194, 239, 366, 404, 441, 476, 513
Addy, John R., Question Box ... 456
Aid for hospital libraries (editorial) ... 506
Alberts, Marion E., M.D., A dedication ... 207
AMA physicians' recognition award (editorial) ... 362
Analogies (editorial) ... 62
Annual University issue (editorial) ... 150
An unusual cause of carpal tunnel syndrome, O'Neil Engeron, M.D., and James O. Stallings, M.D. ... 25
April pediatrics conference ... 67
Appreciate the service ... 138
Aschoff, Carl R., M.D., Question Box ... 171
A top performance, In the Public Interest ... 268

Baker, Howard D., Inflation and medicine 1954-1974 ... 381
Bale, Guru S., Ph.D., Cervical cancer among Iowans ... 53
Bauman, Susan, R.N., and Joel B. Freeman, M.D., Protocol for safe administration of adult parenteral nutritional solutions ... 391
Bell, Donald R., Focus on Iowa medical freshmen ... 137
Blue Cross-Blue Shield now under one roof ... 498
Blue Shield, Supplemental Report ... 299
Blome, G. C., M.D., W. H. DeKraay, M.D., K. E. Lister, M.D., and H. L. Wormhoudt, M.D., Carcinoma of rectum ... 22
Board of Trustees, Supplemental report ... 295
Brand, Richard A., M.D., Late hematogenous infection in total joint replacement ... 388
Brown, Spencer F., Ph.D., M.D., Congenital malformations associated with myelomeningocele ... 101

Cancer case-finding in gross anatomy to stimulate student interest, S. A. Terman, Ph.D., W. K. Metcalf, M.D., N. F. Metcalf, M.B.B.S., and D. Miller, B.A. ... 360
Caplan, Richard M., M.D., Preceptorships in primary care: University of Iowa experience ... 143
Carcinoma of rectum, W. H. DeKraay, M.D., G. C. Blome, M.D., K. E. Lister, M.D., and H. L. Wormhoudt, M.D. ... 22
Case of congenital pyloric stenosis with hematemesis and strong family history, J. C. Justin, M.D. ... 219
Caterine, James M., M.D., Robert F. Valestin, M.D., and Joseph Song, M.D., Male with uterus and fallopian tubes: rare disorder of sexual development ... 385
Cervical cancer among Iowans, Guru S. Bale, Ph.D. ... 53
Child abuse center ... 346
Christmas music (editorial) ... 505
Chubby cherubs (editorial) ... 433
Claims-made form of medical liability insurance coverage, Question Box ... 339
Congenital malformations associated with myelomeningocele, Spencer F. Brown, Ph.D., M.D. ... 101
Continuing Education Courses and Conferences 30, 67, 437, 471, 506
County Society Officers ... 256
Crooked ears (editorial) ... 62
Crucial issues confront medicine, Malcolm C. Todd, M.D. ... 257

Death (editorial) ... 61
Deaths ... 35, 75, 158, 195, 243, 367, 407, 443, 478
De Cesare, William F., M.D., and B. L. Sprague, M.D., High pressure injection injuries to the hand ... 461
Dedication, Marion E. Alberts, M.D. ... 207
De Kraay, W. H., M.D., G. C. Blome, M.D., K. E. Lister, M.D., and H. L. Wormhoudt, M.D., Carcinoma of rectum ... 22
Diagnosing tuberculosis in children, Joanna J. Seibert, M.D., and Lee Frank, M.D. ... 221
Donald W. Dunn, Question Box ... 47
Drug-induced anemia associated with glucose-6-phosphate dehydrogenase deficiency, Fred Meister, Pharm.D., Lee Endsley, M.D., and Joseph D. Schmidt, M.D. ... 465

Eckstein, John W., M.D., Financing medical education—1975 128
Educationally speaking 30, 66, 112, 184, 236, 346, 383, 437, 471, 507
Emergency medical service, State Department of Health ... 109
Endsley, Lee, M.D., Joseph D. Schmidt, M.D., and Fred Meister, Pharm.D., Drug induced anemia associated with glucose-6-phosphate dehydrogenase deficiency ... 465
Engeron, O'Neil, M.D., and James O. Stallings, M.D., An unusual cause of carpal tunnel syndrome ... 25
Ethics of fetal research (editorial) ... 470
Everything's up to date in Iowa City, Mark Stephen Holcomb ... 132
Expanding public health nursing services in Iowa, State Department of Health ... 50

Family Nurse practitioners ... 31
Femoral neck fractures: complications of internal fixation, Stuart L. Weinstein, M.D. ... 17
Fifty year club members ... 253
Financing medical education—1975, John W. Eckstein, M.D. ... 128
Fluid resuscitation of burn patients comparing a crystalloid with a colloid containing solution: a prospective study, Pablo R. Recinos, M.D., Charles A. Hartford, M.D., and Sidney E. Ziffren, M.D. ... 426
Focus on Iowa medical freshmen, Donald R. Bell ... 137
Frank, Lee, M.D., and Joanna J. Seibert, M.D., Diagnosing tuberculosis in children ... 221
Freeman, Joel B., M.D., and Susan Bauman, R.N., Protocol for safe administration of adult parenteral nutritional solutions ... 391

Gearhart, H. A., D.O., and V. B. Mulay, M.D., Segmental infarction of greater omentum ... 225
Gerstbrein, John J., R.P.A., Rex Montgomery, Ph.D., D.Sc., and Denis R. Oliver, Ph.D., Iowa's physician assistant program—1975 ... 139
Grant, Kingsley B., M.D., Zarina Rasheed, M.D., and Richard F. Looker, M.D., Hypercalcemia and its prognostic implications in chronic myelogenous leukemia—a case report ... 423
Green, David, M.B., B.S., Illness engendered by a change of clothes ... 357

Hardin, R. C., M.D., Question Box ... 9
Hartford, Charles A., M.D., Pablo R. Recinos, M.D., and Sidney E. Ziffren, M.D., Fluid resuscitation of burn patients comparing a crystalloid with a colloid containing solution: a prospective study ... 426
Hawtrey, C. E., M.D., E. K. Larson, M.D., and J. D. Schmidt, M.D., Prospective analysis of retrograde ureteral catheterization ... 57
Health aspects of Vietnamese immigration, State Department of Health ... 229
Health care concerns, Mary Louise Smith ... 261
Health problems of Vietnamese refugee children, State Department of Health ... 508
HEW gives IFMC preliminary PSRO nod, In the Public Interest ... 234
High pressure injection injuries to the hand, William F. De Cesare, M.D., and B. L. Sprague, M.D. ... 461
Holcomb, Mark Stephen, Everything's up to date in Iowa City ... 132
HSA minus RMP + CHP = new health planning, In the Public Interest ... 190
Houston, we've gotta problem (editorial) ... 183
Huff, William H., LL.B., Question Box ... 339
Human hyperimmune rabies globulin now available as "drug of choice," State Department of Health ... 472
Hypercalcemia and its prognostic implications in chronic myelogenous leukemia—a case report, Zarina Rasheed, M.D., Richard F. Looker, M.D., and Kingsley B. Grant, M.D. ... 423

ICF and Iowa physicians ... 7
IFMC and PSRO program, Question Box ... 419
Illness engendered by a change of clothes, David Green, M.B., B.S. ... 357
IMS BC/BS program open ... 503
IMS Nominating in March ... 59
Index to minutes ... 324
Inflation and medicine 1954-1974, Howard D. Baker ... 381
Influenza 1974-75 ... 110
Influenza vaccine season, 1975, State Department of Health ... 399
In the Public Interest (A top performance) 268, (HEW gives IFMC preliminary PSRO nod) 234, (HSA minus RMP + CHP = new health planning) 190, (Involvement on behalf of Iowa physicians) 382, (Iowa malpractice situation—a crisis?) 435, (National health insurance) 88, (Pursuit of quality care in Iowa) 455, (Rx for good government: participation) 48, (Seek legislation to ease liability dilemma) 153, (Urge continued family practice impetus) 16, (803 enacted, liability study begins) 348, (In pursuit of good physician/hospital relations) 492
Index to Volume LXV ... 517
Involvement on behalf of Iowa physicians, In the Public Interest ... 382
Iowa Foundation for Medical Care ... 21
Iowa Foundation for Medical Care, Report to IMS House of Delegates ... 297
Iowa immunization action month, State Department of Health ... 420
Iowa malpractice situation—a crisis?, In the Public Interest ... 435
Iowa medical liability data ... 210
Iowa medical liability legislation—summary of House File 803, James B. West, J.D. ... 493
Iowa Medical Miscellany 5, 45, 85, 174, 205, 337, 377, 417, 453, 489
Iowa's physician assistant program—1975, Rex Montgomery, Ph.D., D.Sc., John J. Gerstbrein, R.P.A., and Denis R. Oliver, Ph.D. ... 139

Judicial Council, Report of ... 274
Justin, J. C., M.D., Case of congenital pyloric stenosis with hematemesis and strong family history ... 219

Korson, Selig M., M.D., New commitment law ..... 457

Larson, E. K., M.D., J. D. Schmidt, M.D., and C. E. Hawtrey, M.D., Prospective analysis of retrograde ureteral catheterization ..... 57
Late hematogenous infection in total joint replacement, Richard A. Brand, M.D. ..... 388
Liability data, Iowa medical ..... 210
Liability study begins, 803 enacted, In the Public Interest .. 348
Life and associate memberships ..... 310
Lister, K. E., M.D., G. C. Blome, M.D., W. H. DeKraay, M.D., and H. L. Wormhoudt, M.D., Carcinoma of rectum .. 22
Lister, K. E., M.D., IFMC and PSRO, Question Box ..... 419
Lithium use in manic-depressive illness: practical aspects, Michael J. Taylor, M.D. ..... 180
Looker, Richard F., M.D., Zarina Rasheed, M.D., and Kingsley B. Grant, M.D., Hypercalcemia and its prognostic implications in chronic myelogenous leukemia—a case report . 423
Lousy cities (editorial) ..... 227

Malaria in Iowa, Abner B. Preacher, M.D., and Robin D. Powell, M.D. ..... 175
Male with uterus and fallopian tubes: rare disorder of sexual development, James M. Caterine, M.D., Robert F. Valestin, M.D., and Joseph Song, M.D. ..... 385
March meetings (editorial) ..... 107
Man, his animals and salmonella typhimurium, State Department of Health ..... 10
Medical Assistants ..... 68, 115, 192, 238, 365, 438, 474, 511
Medical liability, Reference Committee Reports on ..... 320
Medical licensure, Question Box ..... 379
Meister, Fred, Pharm.D., Lee Endsley, M.D., and Joseph D. Schmidt, M.D., Drug induced anemia associated with glucose-6-phosphate dehydrogenase deficiency ..... 465
Metcalf, N. F., M.B.B.S., D. Miller, B.A., W. K. Metcalf, M.D., and S. A. Terman, Ph.D., Cancer case finding in gross anatomy to stimulate student interest ..... 360
Metcalf, W. K., M.D., S. A. Terman, Ph.D., N. F. Metcalf, M.B.B.S., and D. Miller, B.A., Cancer case finding in gross anatomy to stimulate student interest ..... 360
Miller, D., B.A., W. K. Metcalf, M.D., S. A. Terman, Ph.D., and N. F. Metcalf, M.B.B.S., Cancer case finding in gross anatomy to stimulate student interest ..... 360
Montgomery, Rex., Ph.D., D.Sc., John J. Gerstbrein, R.P.A., and Denis R. Oliver, Ph.D., Iowa's physician assistant program—1975 ..... 139
Morbidity Report, State Department of Health ..... 327
Mulay, V. B., M.D., and H. A. Gearhart, D.O., Segmental infarction of greater omentum ..... 225

National health insurance, In the Public Interest ..... 88
New AMA CME ..... 66
New commitment law, Selig M. Korson, M.D., F.A.P.A. .... 457
New Year (editorial) ..... 28
Nursing home actions ..... 8

October Is I.A.M. (editorial) ..... 395
Official proceedings of the 1975 sessions of the House of Delegates, Iowa Medical Society ..... 269
Official proceedings of 1975 special session of House of Delegates, Iowa Medical Society ..... 316
Officers and committees of Iowa Medical Society 1975-76 .. 321
Officers, Reports of ..... 271
Okawara, S., M.D., Stereotaxic hypophysectomy ..... 97
Oliver, Denis R., Ph.D., Rex Montgomery, Ph.D., D.Sc., and John J. Gerstbrein, R.P.A., Iowa's physician assistant program—1975 ..... 139
Ophthalmia prophylactic ..... 364, 464
Our reading habits (editorial) ..... 362
Overburdened physician: point of view, B. Frank Vogel, M.D. ..... 51

Physician-pharmacist code of understanding ..... 502
Plan 1975 MECO ..... 67
Powell, Robin D., M.D., and Abner B. Preacher, M.D., Malaria in Iowa ..... 175
Preacher, Abner B., M.D., and Robin D. Powell, M.D., Malaria in Iowa ..... 175
Preceptors for fourth year elective preceptorship, 1973-74 ..... 147
Preceptors for third year required preceptorship, 1973-74 ..... 147
Preceptorships in primary care: University of Iowa experience, Richard M. Caplan, M.D. ..... 143
President's address, Rapidly changing times, Ralph L. Wicks, M.D. ..... 255
President's page 4, 44, 84, 124, 168, 204, 252, 336, 376, 416, 452, 488
Prospective analysis of retrograde ureteral catheterization, C. E. Hawtrey, M.D., E. K. Larson, M.D., and J. D. Schmidt, M.D. ..... 57
Protocol for safe administration of adult parenteral nutritional solutions, Susan Bauman, R.N., and Joel B. Freeman, M.D. ..... 391

Question Box ..... 9, 47, 87, 171, 211, 339, 379, 419, 456, 491

Rakel, Robert E., M.D., Question Box ..... 491
Rasheed, Zarina, M.D., Richard F. Looker, M.D., and Kingsley B. Grant, M.D., Hypercalcemia and its prognositic implications in chronic myelogenous leukemia—a case report 423
Recinos, Palbo R., M.D., Charles A. Hartford, M.D., and Sidney E. Ziffren, M.D., Fluid resuscitation of burn patients comparing a crystalloid with a colloid containing solution: a prospective study ..... 426
Reference Committee Reports ..... 312
Refresher course for Family Practitioners ..... 29
Resolutions ..... 307
Revisions in bacteriologic screening for gonorrhea, State Department of Health ..... 172
Revised recommended treatment schedules for gonorrhea, State Department of Health ..... 342
Rhodes, Sr., J.M., Question Box ..... 379
Right or wrong (editorial) ..... 107
Rx for good government: participation, In the Public Interest ..... 48

Sales tax exemption for certain devices ..... 60
Scanlon Medical Foundation/Iowa Medical Society, Informational Report ..... 301
Scenes from 1975 annual session ..... 264-265
Schmidt, J. D., M.D., E. K. Larson, M.D., and C. E. Hawtrey, M.D., Prospective analysis of retrograde ureteral catheterization ..... 57
Schmidt, Joseph D., M.D., Fred Meister, Pharm.D., and Lee Endsley, M.D., Drug-induced anemia associated with glucose-6-phosphate dehydrogenase deficiency ..... 465
Scientific session ready for launch, IMS ..... 113
Scott, Larry D., M.D., Wilson's disease: investigation of an Iowa family ..... 349
Seek legislation to ease liability dilemma, In the Public Interest ..... 153
Segmental infarction of greater omentum, V. B. Mulay, M.D., and H. A. Gearhart, D.O. ..... 225
Seibert, Joanna J., M.D., and Lee Frank, M.D., Diagnosing tuberculosis in children ..... 221
Smith, Mary Louise, Health care concerns ..... 261
Song, Joseph, M.D., Robert F. Valestin, M.D., and James M. Caterine, M.D., Male with uterus and fallopian tubes: rare disorder of sexual development ..... 385
Specialty briefing ..... 112
Special Committees, Reports of ..... 286
Special Committees, Supplemental Reports of ..... 306
Sprague, B. L., M.D., and William F. De Cesare, M.D., High pressure injection injuries to the hand ..... 461
Standing Committees, Reports of ..... 274
Standing Committees, Supplemental reports of ..... 302
Stallings, James O., M.D., and O'Neil Engeron, M.D., An unusual cause of carpal tunnel syndrome ..... 25
State Department of Health 10 (Man, his animals and salmonella typhimurium), 50 (Expanding public health nursing services in Iowa), 109 (Emergency medical service), 155, 172 (Revisions in bacteriologic screening for gonorrhea), 229 (Health aspects of Vietnamese immigration), 342 (Revised recommended treatment schedules for gonorrhea), 399 (1975 influenza vaccine season), 420 (Iowa immunization action month), 472 (Human hyperimmune rabies globulin now available as "drug of choice"), 508 (Health problems of Vietnamese refugee children)
Statement from John W. Eckstein, M.D., Dean, U. of I. College of Medicine ..... 127
Stereotaxic hypophysectomy, S. Okawara, M.D. ..... 97
Surgical treatment of obesity ..... 497

Tackle key issues at March meetings ..... 49
Taylor, Michael J., M.D., Lithium use in manic-depressive illness: practical aspects ..... 180
Terman, S. A., Ph.D., W. K. Metcalf, M.D., N. F. Metcalf, M.B.B.S., and D. Miller, B.A., Cancer case finding in gross anatomy to stimulate student interest ..... 360
Thanksgiving (editorial) ..... 469
Thanks to preceptors ..... 146
Todd, Malcolm C., M.D., Crucial issues confront medicine .. 257
Treasurer, Report of ..... 273

Urge continued family practice impetus, In the Public Interest ..... 16

Vaginal voiding: an introduction, Richard L. Vaught, M.D. . 213
Valestin, Robert F., M.D., James M. Caterine, M.D., and Joseph Song, M.D., Male with uterus and fallopian tubes: rare disorder of sexual development ..... 385
Vaught, Richard L., M.D., Vaginal voiding: an introduction . 213
Views of scientific editor ..... 52
Vogel, B. Frank, M.D., Overburdened physician: point of view ..... 51

Weight reduction weighed (editorial) ..... 28
Weinstein, Stuart L., M.D., Femoral neck fractures: complications of internal fixation ..... 17
West, James B., J.D., Iowa medical liabiltiy legislation—summary of House File 803 ..... 493

We've come a long way, baby! ..... 209
What goes up must come down (editorial) ..... 227
What'll you have? (editorial) ..... 61
Where am I? How are things going? (editorial) ..... 434
Wicks, Ralph L., M.D., President's address, Rapidly changing times ..... 225
Wilson's disease: investigation of an Iowa family, Larry D. Scott, M.D. ..... 349
Woe of Surgeon Joe (Editorial) ..... 396
Wormhoudt, H. L., M.D., K. E. Lister, M.D., G. C. Blome, M.D., W. H. De Kraay, M.D., Carcinoma of rectum ..... 22
Ziffren, Sidney E., M.D., Pablo R. Recinos, M.D., and Charles A. Hartford, M.D., Fluid resuscitation of burn patients comparing a crystalloid with a colloid containing solution: a prospective study ..... 426

## MEDICAL ASSISTANTS

*(Continued from page 511)*

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Presented at the Convention was the following resolution:

WHEREAS, Our association is beginning our 20th year as a professional organization, and

WHEREAS, The American Medical Association has been a valuable contributor in guidance and assistance to A.A.M.A. during our first two decades, and

WHEREAS, The American Medical Association has provided grant funds to help finance our educational endeavors, and

WHEREAS, The American Medical Association, through its Council on Medical Education, aided A.A.M.A. in obtaining recognition by the Department of Health, Education and Welfare to accredit medical assistant curricula, therefore be it

*Resolved*, That the Officers and Trustees of the American Medical Association be informed that the membership of A.A.M.A. is deeply appreciative of all assistance received in obtaining our association's goals and we look forward to many future decades of allegiance and rapport with A.M.A. in areas of mutual concern.

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## INDEX TO ADVERTISERS


Burroughs Wellcome ..... 492

Lilly, Eli, & Company ..... 485

Medical Protective Company ..... 519

Merck, Sharp & Dohme ..... 494B, C, D

Nassau Medical Congress ..... 515

Pharmaceutical Manufacturers Association ..... 504B, C

Prouty Company ..... 516

Robins, A. H., & Co. ..... 490A, B

Roche Laboratories ..... 486-487, 523, 524

Roerig, J. B., & Company ..... 504D

Searle, G. D., & Company ..... 504, 504A

Smith, Kline and French Laboratories ..... 494A

Younkers ..... 512




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